MEDICARE CATASTROPHIC PROTECTION ACT

HEARING

BEFORE THE

SUBCOMMITTEE ON COMPENSATION AND EMPLOYEE BENEFITS

OF THE

COMMITTEE ON POST OFFICE AND CIVIL SERVICE HOUSE OF REPRESENTATIVES

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MEDICARE CATASTROPHIC PROTECTION ACT

WEDNESDAY, OCTOBER 7, 1987

HOUSE OF REPRESENTATIVES,
COMMITTEE ON POST OFFICE AND CIVIL SERVICE,
SUBCOMMITTEE ON COMPENSATION AND EMPLOYEE BENEFITS,
Washington, DC.

The subcommittee met, pursuant to call, at 10 a.m., in room 311, Cannon House Office Building, Hon. Gary L. Ackerman (chairman of the subcommittee) presiding.

Mr. ACKERMAN. The subcommittee will come to order.

Today the Subcommittee on Compensation and Employee Benefits will conduct a hearing on the impact which H.R. 2470, the Medicare Catastrophic Protection Act, would have on the Federal Employee Health Benefits Program and its participants. All Americans are affected by the constantly escalating cost of health care. Senior citizens often suffer the most because they tend to experience chronic conditions and require more frequent medical care and most senior citizens face this struggle on fixed incomes.

On July 22 the House responded to the fear of America's elderly by the cost of health care by passing the Medicare Catastrophic Protection Act; however, in the haste to provide America's seniors with catastrophic medical insurance, Congress must not overlook the impact on Federal retirees who have given the major part of their lives to public service.

H.R. 2470 imposes on Federal retirees a discriminatory medicare tax. It also forces them to purchase medical insurance which they do not need, and often cannot afford. Under H.R. 2470, all medicare-eligible individuals would be required to pay a supplemental premium based on adjusted gross income. Since civil service retirement income is almost totally taxable, while social security is almost entirely tax free, civil service retirees would be charged a drastically higher premium than other retirees.

Moreover, Medicare-eligible Federal retirees would be charged these higher premiums for coverage which they already have through their Federal health plans.

Since 1982, all FEHBP enrollees have had catastrophic coverage. Under H.R. 2470, medicare-eligible Federal annuitants would be paying twice for the same coverage. This mandated double coverage is patently unfair. Many people cannot afford to pay for two overlapping insurance policies, yet Federal annuitants cannot forego their FEHBP coverage, and later re-enroll if Medicare becomes too costly or if Medicare benefits are reduced.

Once retirees drop out of FEHBP they can never return. I hope the Medicare Catastrophic Protection Act will be altered to address

the special needs of people who have given so much to their country. In the meantime, this subcommittee is actively seeking solutions to the problems which would be caused by enactment of the Medicare Catastrophic Protection Act.

Today the subcommittee will hear from representatives of the Federal Government Service Task Force, the Office of Personnel Management, the National Association of Retired Federal Employees, as well as health plan participants in the FEHBP and some of our colleagues here in the Congress as well.

The Chair recognizes the distinguished colleague from Maryland, Mrs. Morella.

Mrs. MORELLA. Thank you, Mr. Chairman.

I really want to thank you for holding this very important meeting to examine the impact of the Medicare Catastrophic Protection Act on Federal retirees and the Federal employee health benefits program. I appreciate this opportunity to again express my deep concern with the problems this bill poses to this important group, as well as to a number of other retirees who already receive catastrophic health benefits in their existing health plans.

These retirees would be required to pay premiums for health benefits which they already receive through the Federal employee health benefits program and to pay a higher income-related premium than social security recipients, because Federal pensions are fully taxable. This double hit would take place at a time when Medicare premiums are scheduled to increase by 38.5 percent next year, and when premiums for the Federal employee health benefits program are slated to rise by an average of 31 percent.

As you know, Mr. Chairman, the Senate Subcommittee on Federal Services, the Post Office, and Civil Service held a similar hearing in late September. As is the case today, Senator Pryor brought together a number of witnesses representing OPM, NARFE, Federal and posted employee groups, and health insurance providers, to discuss possible solutions. While there was no consensus about the best course of action to take, there was an important exchange of ideas among the various groups. It is my hope that today we can expand on that discussion and begin to outline a plan for action.

The Senate still has not acted on the bill, and it appears that it will be at least a few more weeks before it is considered. Mr. Chairman, let us all work together to arrive at some solutions which can be pursued as amendments to the Senate bill.

I am particularly interested in hearing more about the OPM study of the Federal Employee Health Benefits Program, with its focus on the problems posed by the Medicare legislation. I hope it will be completed in time to contribute to the revision of this bill and will help to provide data which is currently unavailable, but needed, to accurately address this situation.

Mr. Chairman, the burden of this bill on Federal retirees is far too much to ask of anyone. I urge the members of this subcommittee and committee to work for a resolution of these problems and prevent the further erosion of benefits for our Federal retirees. This meeting demonstrates that commitment.

Thank you, Mr. Chairman. I must leave for a press conference. I will return. I want my distinguished colleagues who have also testi-

fied with me on the Senate side to know that I will read their remarks very carefully and I shall be right back.

Thank you.

Mr. ACKERMAN. Thank you. I appreciate your statement.

Mr. Myers.

Mr. MYERS. Thank you, Mr. Chairman.

I, too, commend you for having these hearings. I think we all support a catastrophic insurance program, if we can design one and this is what this hearing is all about. I do have a prepared statement I wish to be put in the record. I will not take the time, because we have a number of witnesses this morning. I think it is more important for us to hear you than for you to hear us. So I will put my statement in the record at this point.

Mr. ACKERMAN. Without objection.

[The statement of Mr. Myers follows:]

PREPARED STATEMENT OF CONGRESSMAN JOHN MYERS

Mr. Chairman, when President Reagan launched his catastrophic health care proposal over a year ago, most Americans were seized by the concept. Protection from the financial ravages of catastrophic illness was the right idea at the right time.

However, somewhere this idea of basic catastrophic care was lost and now we discover in the rush to pass a catastrophic health care bill, there are provisions in H.R. 2470 that will seriously hurt federal and state retirees, and some HMO participants.

Under the bill which passed the House of Representatives, federal retirees will be forced to pay for coverage that they already receive under the Federal Employees Health Benefit program (FEHBP). In addition, there are other problems with this bill that must be addressed by the Senate before it is enacted into law.

I welcome to these hearings concerned Members of Congress, Administration officials, and industry and labor representatives with their ideas on the best approach to solving this difficult problem.

Mr. ACKERMAN. We are pleased to have this morning a very distinguished group of our congressional colleagues to testify before us. I know everybody has a busy schedule so we will get right down to it.

First on the panel will be the Representative from Maryland, Steny Hoyer. Welcome.

STATEMENT OF HON. STENY HOYER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Mr. HOYER. Thank you, Mr. Chairman, Mr. Myers and the staff of the committee on which I used to serve.

I want to thank you for this opportunity. As you pointed out to my left is Congressman Norm Dicks who is cochair of the Federal Service Task Force. On my right is Congressman Frank Wolf, a member of the task force and a member of its executive committee and as I always point out, one of the most active proponents of positive actions with reference to Federal employees.

We appreciate this opportunity to testify, Mr. Chairman. I would, as everybody else has done, like to express my deep appreciation for your invitation to us here to testify. I also commend your leadership in holding these hearings, hearings I fully expect will detail the harsh inequities Federal and military employees face if this catastrophic health legislation becomes law in its current form.

I would point out they are not the only ones so situated. It is not exclusively a Federal employees' problem. I think it is important for us who represent so many Federal employees, to continue to re-

iterate, as we did with respect to the 3-year recovery rule, that it was not Federal employees alone who was adversely affected.

Joining me today are in addition to Congressman Dicks and Congressman Wolf, Congressman Vic Fazio, who is also a cochairman of the Federal Service Task Force, and again one of our leading advocates of Federal employee interest in the Congress.

First, let me stress that I support the objectives of the catastrophic health care bill. We must recognize the changing health needs of America's seniors and their right to quality health care.

At the same time, this Congress cannot overlook the financial yoke this legislation would strap on 4 million Federal and military retirees.

At recent hearings before the Senate Subcommittee on Federal Services, Post Office and Civil Service, witness after witness testified that Federal retirees would pay more for catastrophic health premiums than private sector retirees. Compounding the problem, of course, is the fact that Federal retirees already pay for this very same coverage under the Federal Employees Health Benefit Plan [FEHBP]. That, of course, is the problem.

In testimony before the Senate, the task force also pointed out that the financial burden placed on Federal retirees becomes even more pronounced when you consider the additional health benefit costs Government retirees will face next year.

These additional retiree costs in 1988 include an average 31 percent hike in premiums and a 30-plus percent boost in part B Medicare premiums, which is required by law to meet escalating Medicare costs. Mr. Chairman, these prohibitive increases have propelled Federal retiree health costs into orbit.

Part of our collective mission today is to explore ways we can remedy this problem. Many proposals to remove the inequities are being considered. I commented on a number of them in my testimony before the Senate.

One stop-gap measure would delay the effective date of the bill for federal retirees, giving Congress additional time to resolve the problems—problems which will likely entail complex program changes. I think that short-term solution may be advisable if, in fact, the catastrophic bill is going to move this year. Clearly the plans are to move it this year, but there are some doubts.

Another proposal, Mr. Chairman, develops a formula to place the taxable civil service retirement annuity on a more equal footing with a private sector pension that is partially nontaxable because of its social security component.

This proposal attempts to restore equity to the funding component of the catastrophic benefit. The success of such a solution, however, will clearly require the imprimatur of both the Senate Finance Committee and the House Ways and Means Committee.

A third proposal would direct OPM to study how carriers can provide supplemental or medigap-type policies for Government retirees over age 65. An FEHB medigap policy which covers costs not provided by medicare would eliminate the duplicative catastrophic coverage this bill imposes. I am sure you are aware of the fact Blue Cross/Blue Shield has come out with a proposal. I have not had the opportunity to review it, nor have I seen Mr. Causey's column this

morning, but I understand he refers to it. I am not sure how that fits into the suggestion I have just made.

The medigap proposal, however, should be carefully reviewed because it could mean higher premiums for other enrollees and higher costs to the Government.

Nonetheless, there is good reason to suspect Federal retirees over the age of 65 are paying too much for their FEHB health care. They pay the same rates as other plan participants but they have lower claim costs because Medicare is the primary payer of their health care costs. That is a controversial issue, one of which I know the Chairman is aware, but it is a component of this problem.

If Government retirees were given a lower cost option, similar to one given private sector retirees, that cross-subsidy would be reduced. Of course, the additional costs for other enrollees and the Government is a problem.

Mr. Chairman, under your leadership I fully expect we can solve these problems and improve health care for America's seniors. Both the leadership and the staff resources of the Federal Government Service Task Force remain at your disposal to assist in any way we can.

At this time, Mr. Chairman, I would like to recognize or have you recognize, Congressman Dicks.

Mr. ACKERMAN. Congressman Dicks.

STATEMENT OF HON. NORM DICKS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Mr. DICKS. I appreciate that very much.

Mr. Chairman, I am very delighted that I am able to be here today to testify before this distinguished subcommittee and to be with three of my colleagues in the task force. I must say that they have done an enormous amount of work on this issue and I am just pleased to be able to testify.

My distinguished colleagues and cochairman of the Federal Government Service Task Force, Representative Steny Hoyer, has covered the waterfront this morning pointing out the major problems this legislation poses for Federal retirees. I don't wish to take up the subcommittee's time by duplicating that testimony.

I would, however, like to reiterate one point Representative Hoyer focused on, and expand on it a bit further. He explored not only the effect of the catastrophic bill on Federal retirees' pocketbooks, but the cumulative impact of that bill when coupled with an average 31 percent premium hike in their health benefit plans and a 30-plus percent hike in Medicare part B premiums. This "triple whammy" on the Federal retiree makes the impact of the catastrophic bill even more intolerable than it seems at first blush.

That, however, is not the only context in which this legislation should be viewed. When you review the policy and program changes affecting Federal retirees over the last few years, the unfairness of this situation is even more obvious.

In recent years Congress has legislated major changes affecting both the tax and social security systems. In our quest to increase revenues to offset a mounting deficit, "simplify" the tax code and provide a needed infusion of funds to a financially unbalanced

social security system, reforms were made that unfairly singles out federal employee and retiree benefits for cuts.

For example, in 1983 the Congress passed legislation to reform a financially unstable social security system. In an attempt to find needed revenues and defray program costs, the legislation required Federal employees hired after 1984 to pay into the system.

What was the result of that action? It sent shock waves through the Federal employee and retiree community. Why? Because many realized that action would require the development of a new retirement system for those civil servants. They feared a new system would (1) provide fewer retirement benefits, (2) destabilize their Civil Service Retirement System, or both.

Employee participation in the social security system also precipitated the House Ways and Means Committee action to impose both a windfall and spouse pension benefit offset to their pensions. What was the net result of those actions? A reduction in their benefits.

Then along came 1986, the year of "tax simplification." When the tax reform bill finally passed, did the Federal retirement system escape their tinkering? I am sure you can guess by now that the answer is "no."

It was then that the Ways and Means Committee decided to repeal the 3-year recovery rule, under which Federal retirees could recoup their already taxed retirement contributions before their annuity became taxable.

To add insult to injury, the action was made retroactive so that recently retired Federal employees had the game changed on them after the fact.

Well Mr. Chairman, as the President likes to say "here we go again". But this time we have an opportunity to do something right for Federal retirees.

We cannot stand by and let Government retirees suffer this injustice. Sadly, the legislation hurts those people who can least afford it: retirees on a fixed income. They have worked hard for many years and have earned their benefits.

They are not asking for special benefits. They ask only to be treated fairly. We owe them that.

As always, Mr. Chairman, I offer my full cooperation and support in your efforts to rectify this wrong.

Mr. ACKERMAN. Thank you very much. We appreciate the statement and the fashion in which it was delivered. Who would like to be next?

Mr. HOYER. I would like Congressman Fazio next.

Mr. ACKERMAN. In that case, Congressman Fazio, welcome.

STATEMENT OF HON. VIC FAZIO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. FAZIO. I appreciate the influence of my cochairman with you, Mr. Chairman. I want to thank both you and Mr. Myers for convening this hearing and giving us an opportunity to hear a problem that we hope, as Frank Wolf and I were just saying, that the Ways and Means Committee will also take a look at.

Mr. Chairman, we really do appreciate this chance to testify this morning on the impact of the catastrophic loss prevention act on federal retirees. As cochairmen of the Federal Government Service Task Force, Representatives Hoyer, Dicks and I have agreed to discuss different aspects of the problem this bill poses for Federal retirees.

Mr. ACKERMAN. I thought it was a coincidence you guys were so prepared.

Mr. FAZIO. It could be a coincidence under most circumstances, Mr. Chairman, but we are trying hard to do a little better.

Anyway, I think it is clear Steny has defined the immediate adverse affect of this legislation on Federal retirees, as well as some avenues the subcommittee could pursue to correct that problem. Representative Dicks provided an historical context within which to view the cumulative impact of this legislation on federal annuitants. I wholeheartedly agree with their assessments.

My testimony will focus on a missing element of catastrophic care that I also believe the subcommittee should be reviewing at this time: long-term custodial and nursing home care.

The Budget Committee Task Force had a meeting on this just the other day and 80 different social service organizations have banded together to make sure this becomes an issue in the next presidential campaign.

The Catastrophic Loss Prevention Act expands catastrophic health care benefits for millions of Americans and I fully support the expansion. But we must not lose sight of the fact that we have yet to fill the biggest void in catastrophic care policy—reimbursement for long-term custodial care provided at home and in nursing facilities.

This type of coverage is the most important health care protection that can be provided to America's rapidly increasing elderly population. In 1980, there were 25 million people in this country over the age of 65. Those 85 or older make up the fastest growing segment of our population. I heard a statistic there are 21 times as many people in the over-80 category as there were at the turn of the century, and this group of so-called frail elderly do constitute our fastest growing population element.

As we age, we all know we are prone to losing the agility with which we perform even the most routine tasks. We also become more likely to fall victim to chronic illness. These are realities of the aging process—and they make long term nursing and nursing home care a necessity for many older Americans.

Some experts predict almost half of all individuals will require professional long-term care services after the age of 65. Over 80 percent of the elderly population believes Medicare will cover their long-term health care costs. But neither medicare nor the FEHBP provide coverage for these services.

Medicare will pay up to 100 days of hospitalization care per year and the catastrophic legislation expands that benefit. Hospital care, however, is used an average of only 27 days per year.

For most of our elderly "long-term care" means personal care, routine health care and social services provided at home or in nursing facilities. The cost of nursing home care can vary from $15,000 to $50,000 per year, at this time it is averaging $22,000 a year, and

over 50 percent of these costs are paid out-of-pocket by older Americans.

The financial burden of long-term care quickly exhausts the limited resources of retirees on a fixed income. Only after the elderly are overcome by poverty will nursing home expenses be paid by Medicaid—often a humiliating blow to a proud generation of Americans, Americans who must spend down their assets in order to qualify for the benefits.

As the need for long-term care increases, the provision of these benefits becomes even more imperative. We must begin to address this need immediately.

Representative Hoyer spoke of the need to develop a less comprehensive program for retirees under the Federal Employees Health Benefit Program [FEHBP]—a plan which fills in the gaps in health care coverage not already provided by Medicare.

If that option is explored, I strongly encourage this subcommittee to require carriers to adopt a concept proposed by Representative Mary Rose Oakar in a bill she recently introduced. Her legislation, the Federal Employees Long-Term Health Care Act of 1987 (H.R. 384), calls for a demonstration project to test the feasibility of providing long-term social and health care benefits to federal employees and retirees under FEHBP.

The Federal Government has long been a leader in providing progressive benefits to its employees. The FEHBP is viewed as a model health care system, a system which has been duplicated by some large private sector employers.

I would like to see the Federal Government take the lead on this health issue—and I hope many employers will follow that lead.

With an ever increasing elderly population we must take these progressive steps now. The need is real and the quality of life for elderly Americans is at stake.

The political movement has begun and this committee could play a crucial role in letting America see just how this problem could be addressed.

Thank you, Mr. Chairman.

Mr. HOYER. Mr. Chairman, last, one of the most active, effective advocates on behalf of Federal employee issues, the Task Force is a bipartisan group. Sometimes it appears to be a Democratic group because there are obviously more Democrats than Republicans in the Congress, but I want to say Frank Wolf is one of our hardest working Members and most effective advocates. I reiterate that because we are very appreciative of the efforts he makes.

Mr. WOLF. Thank you, Steny.

Mr. ACKERMAN. Thank you very much. Welcome again before the subcommittee and thank you for your always fine testimony and your great interest in our Federal employees.

STATEMENT OF HON. FRANK WOLF, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA

Mr. WOLF. Thank you, Mr. Chairman. I commend you on holding these hearings in such a timely manner because the issue we are addressing today is one of national importance. Without a doubt the time has come to recognize the changing needs of an aging

America. One need that has been clearly established since the President proposed it last year is that of protecting our elderly from the financial ruin that a catastrophic illness can bring.

I strongly believe that catastrophic care is important, but I also believe that we must address the financial concerns of the elderly on how to meet the high costs of nursing home or other long-term care.

I believe that Congress needs to address the day-to-day financial problems which our elderly face when providing for their long-term care—the high costs of Medicare premiums, taxes, and long-term health care.

Even well-intentioned proposals can become burdensome if the costs outweigh the gains. Under current legislative proposals, the vast majority of the elderly—some 70 percent who already have private-sector insurance policies to supplement their Medicare coverage—would face premium increases which could be prohibitive. Medicare premiums are already expected to rise 38.5 percent next year without any expansion of the system. Additional increases could force individuals to choose between dropping their Medicare coverage or dropping their private insurance, which would obviously be very bad.

The House-passed legislation unfairly singled out Federal, State, and military retirees to pay a disproportionate share of the cost of the catastrophic care program. Most Federal retirees are already covered for catastrophic illnesses because they are enrolled in the Federal Employee Health Benefits plan as well as Medicare A and Medicare B. The FEHB plans include many of the benefits that the proposals now before Congress offer. As the legislation now stands, Federal retirees would have to pay substantially more for Medicare, but would receive practically no additional coverage.

The provisions which link the tax liability of Medicare beneficiaries to their taxable income are particularly unfair. Federal annuities are fully taxed, while social security recipients receive largely tax-free benefits. The National Association of Retired Federal Employees (NARFE) estimates that a Federal retiree, with an average annuity of $13,566 a year, would have to pay $530 a year in supplemental premiums, while other retirees with the same income would pay only about $110 in added premiums.

This means that retirees with fully taxable pensions—including Federal, State, and military annuitants—will be paying substantially more for their insurance but would be receiving practically no added benefits. The House-passed plan would not even give these individuals a choice in the matter.

Mr. Chairman, I hope that the final version of Medicare catastrophic health insurance legislation responds to the health care concerns of all retirees. I urge the committee to consider the costs that individuals who have already paid for catastrophic health insurance would have to face under a major expansion of the Medicare program. These costs would be prohibitive for many individuals, would be particularly unfair to Federal, State, and military retirees, and worst of all would not give our elderly a choice. Before catastrophic care legislation becomes law, these important questions need to be addressed. Thank you for your consideration.

In closing, I think it is a fair statement, Mr. Chairman, to say OPM has not been a friend of the Federal employee and Federal retiree, but I think it is even more fair to say that in this Congress and several past Congresses have been even less of a friend of the Federal employee and Federal retiree.

Norm Dicks makes it clear Federal employees are taking hit after hit after hit after hit. This legislation is just the final blow, if you will, to the retirees who have already been hard hit. So I am just hopeful that this committee is able to do something to rein in or to change this legislation, which unfortunately, has already passed the House and will be coming up in the next week or two in the Senate.

I thank the chairman for holding the hearings.

Mr. HOYER. Mr. Chairman, Mr. Dicks and Mr. Fazio had to go and I have to be on the floor as you know. We appreciate your accommodating us early. This is a problem that I think is universally perceived. We had sitting in the room with you, Mr. Chairman, five members of the Appropriations Committee. I leaned over to Mr. Dicks and I said we might be in better shape if we had sitting with you in this room five members of the Ways and Means Committee. Maybe some of our Federal employee advocates would like that.

Notwithstanding that, it is perceived, I think, as an unfair position in which we have put Federal retirees by members of the Ways and Means Committee. So I think united we can make our point and try to come up with solutions, and we will look forward to working closely with you and your staff.

Mr. ACKERMAN. We greatly appreciate the fine work of the task force and this subcommittee certainly appreciates the lengths that the task force has gone to to coordinate the testimony that you presented this morning so that we would not have repetition and overlap. It certainly helps to move things forward and we appreciate the degree of organization that you have come in with, as well as the importance and weightiness of your remarks.

Mr. HOYER. Thank you, Mr. Chairman.

Thank you, Mr. Myers.

Mr. ACKERMAN. We will now hear from Ms. Jean Barber, the Associate Director, Retirement and Insurance Group, Office of Personnel Management.

STATEMENT OF JEAN M. BARBER, ASSOCIATE DIRECTOR, RETIREMENT AND INSURANCE GROUP, OFFICE OF PERSONNEL MANAGEMENT

Ms. BARBER. Thank you, Mr. Chairman. Thank you for inviting me to appear today to present the views of the Office of Personnel Management on the impact of pending Medicare legislation on the Federal Employees Health Benefit Program and on Federal annuitants. To make sure we start from a common understanding, I would like to briefly review the current interaction between Medicare and FEHB. The overwhelming majority, 78 percent, of Federal retirees, participate in the FEHB program. Of this group, a large majority, approximately 760,000 of those age 65 and older, are also covered by part A of Medicare and most also elect to participate under part B.

Typically the Medicare eligible retiree enrolls in an FEHB plan to fill the gaps in his Medicare coverage. Under current law these gaps include both the Medicare deductible and coinsurance amounts plus prescription drugs and catastrophic coverage. By combining the two programs, the retiree is able to protect himself against most medical costs associated with acute illness.

The sizable income-related premiums associated with the expanded coverage under H.R. 2470 would make it extremely burdensome for Federal annuitants to continue to carry both full Medicare and full FEHB coverage. Since the House bill attaches a supplemental premium to the nonoptional Medicare part A and provides a prescription drug benefit as well, we would anticipate if this bill were enacted a massive withdrawal of Medicare annuitants from the FEHB program.

We would also no doubt see increased pressure for a separate Medigap insurance plan within the FEHB. Either of these events would have serious implications for the rest of the program. You need only two pieces of information to understand the impact that they would have. The first fact is that Federal retirees, including the Medicare eligibles, are concentrated in a very few FEHB plans. Sixty-five percent of all retirees are enrolled in the Blue Cross and Aetna plans, and 5 of the nearly 400 participating plans account for 80 percent of total annuitant enrollment. Therefore, a change in the behavior of Medicare eligible annuitants will impact greatly on a few of the plans and, at least in the first instance, hardly at all on many others.

The second piece of information is that the presence of Medicare enrollees generally has a subsidizing effect on the plans in which these individuals are enrolled. While older people in general are far more expensive to insure than younger people, from an FEHB perspective, since Medicare is the primary payer, retirees with Medicare A and B coverage are relatively good risks. Their presence in the plans with expensive populations of non-Medicare eligibles helps spread the risk over a broader base. If they leave, quite simply, the premiums for the people remaining will have to be increased.

The extent of the increase will depend on the particular mix of enrollees in a given plan. We believe in the two Governmentwide high option plans, it could be quite significant and we believe further that the continued availability of these plans might be threatened. Since the FEHB is a multiple choice, competitive program with annual open seasons, the demise of two large plans would have repercussions throughout the entire program.

We believe that the Medicare catastrophic legislation is really highlighting a problem that has existed in the program for quite some time, and that problem is the maldistribution of risks across the many participating plans. That maldistribution has become so serious that the basic principles of group insurance have eroded in the FEHBP.

Because we have been concerned about this, we have initiated a comprehensive study and evaluation of the FEHB which will include an evaluation of the Medicare/FEHB interaction. When the Medicare catastrophic legislation became imminent, we revised our priorities and made that particular piece of the study the first

order of business. We let a contract for assistance on the study on September 28 of this year.

I would also like to tell you that, picking up on a suggestion that you made, Mr. Chairman, we have contacted the Department of Health and Human Services to get their cooperation to make a data file match between our FEHB enrollees and Medicare beneficiary information that they possess. When this match is made, we will for the first time have accurate and complete information on the Medicare eligibility of our retirees and their distribution across the program, so I thank you for that suggestion. I am informed that we will probably have the results of that match in early November.

I will be happy to answer any questions you may have.

Mr. ACKERMAN. Thank you.

When was it you said we could expect the results?

Ms. BARBER. Of the file match?

Mr. ACKERMAN. Yes.

Ms. BARBER. We have heard from social security that they think they will be able to deliver it in very early November.

Mr. ACKERMAN. Thank you. Who is it that will be doing the study that has been awarded?

Ms. BARBER. The contract was awarded to the consulting firm of Towers, Perrin, Forster and Crosby.

Mr. ACKERMAN. This is the first hearing we have had since OPM announced the premiums under FEHBP would increase on the average, everybody has said some 31 percent without any changes. A lot of people have been asking about OPM stewardship of the program. Not having the answers myself, I would like to give you the opportunity possibly to respond to that.

Has OPM been doing everything that it can to keep FEHBP premiums down? Can the government's buying power, for example, when plans contract for a million-odd drugs, be used to keep these prices restrained?

Ms. BARBER. Sir, we believe there are two factions at work here. We think there are forces in the health care economy that are driving our program as well as other health insurance programs. We also believe there are some structural difficulties in the FEHB which perhaps can and should be looked at. As far as OPM stewardship is concerned, I believe we have been doing everything within our statutory power. In the rate setting this summer, we either accepted the rate proposed or lowered it in all but five cases. There were only five cases in which we felt that the rate proposed was inadequate.

So I think we did everything we could to get the best that we could for Federal employees. The 31 percent rate increase is shocking. It is shocking to all of us, I believe. But if you look at what is going on in the rest of the industry, it is not out of line. As has been mentioned here this morning, the Medicare part B increase is very similar and large private sector contracts are also following a similar pattern. There are, no doubt, massive problems in the health care economy itself, and, we believe, also some special problems in the FEHB that may be exacerbating the situation.

Mr. ACKERMAN. You mentioned that one of the results of passage of the catastrophic bill would be movement that would permit the

FEHB plan to offer medigap policies. In your estimation what impact would medigap policies have on the present plans?

Ms. BARBER. If we offered a separate medigap policy, then the Medicare eligibles would all go to that plan and it would have the same effect on the plans they were leaving as if they left the FEHB altogether. In other words, those plans that are now getting the subsidy from having the Medicare eligibles enrolled would no longer get it.

Mr. ACKERMAN. Several other solutions have been mentioned, including the special entitlement by which OPM would repay Federal retirees to cover the amount of double coverage or repayment to the plans who could then offer other benefits such as long-term care.

Does OPM have a position on the feasibility of any of those suggestions?

Ms. BARBER. Some of them, Mr. Chairman, I have only seen in the sketchiest form and I have so many questions about them that until I understand them better, I don't believe I could address them for you.

Mr. ACKERMAN. Have you had a chance to look at the new proposal from Blue Cross/Blue Shield?

Ms. BARBER. I heard about it yesterday. It was just handed to me as I walked in here this morning.

Mr. ACKERMAN. We would appreciate it if you had a chance to look at that, to share some of your thoughts with the subcommittee.

Ms. BARBER. I would be glad to.

Mr. ACKERMAN. We will be hearing testimony about how Federal retirees under FEHBP help to subsidize active workers and you mentioned that in your testimony as well. A key question I think is, Is that subsidy fair? Are there any statistics on how extensive that subsidy really is? Will that be part of the study that you mentioned?

Ms. BARBER. It will certainly be part of the study and it was on our work agenda before this issue arose. We have been concerned for quite a few years now that our Medicare eligible enrollees do not have a plan that is designed specifically for their needs and that they are subsidizing the others. The difficulty is, once you start pulling out a large group like that, other things begin to unravel and, therefore, we think we need to look at special coverage for Medicare eligibles in the context of a larger program restructuring.

Mr. ACKERMAN. The initial part of the question, I think, is part of the crux of why we are here. Is it fair?

Ms. BARBER. Sir, we have been concerned about it for quite some time. Not only is it perceived as unfair, it is terribly confusing to the Medicare eligibles themselves. We get a great deal of correspondence asking us to explain it. It is a difficult benefit for them to understand and to understand the inter-relationship between the two. So no, I do not think the current situation is a desirable one.

Mr. ACKERMAN. So we have somehow inadvertently created an untenable situation as far as equity is concerned?

Ms. BARBER. Well, you know, the FEHB is older than Medicare and the situation evolved over a number of years. Until 1983, at least by virtue of Federal employment, Federal employees were not covered by Medicare. Many of them acquired it through other employment. So the size and scope of the problem has simply grown over the years as more and more Federal annuitants have acquired Medicare coverage. There is no one point in time when it suddenly popped up. It just grew gradually over a long period of time.

Mr. ACKERMAN. Thank you. We most assuredly will have some additional questions as we gather additional information from you and the agency. We would like the opportunity to extend to you those questions to have you respond in writing if you would.

Ms. BARBER. I'd be glad to, sir.

[The information follows:]

United States
Office of Personnel Management
Washington, D.C. 20415

NOV 6 1987

In Reply Refer To

Your Reference

Honorable Gary L. Ackerman
Chairman, Subcommittee on Compensation
and Employee Benefits
Committee on Post Office and Civil Serivce
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Ackerman:

At the subcommittee hearing on catastrophic protection held October 7, 1987, you asked for my views on a Blue Cross/Blue Shield proposal relating to the Medicare catastrophic coverage legislation.

Since my appearance before the subcommittee, I have had a chance to review the Blue Cross/Blue Shield proposal. That proposal would appear to alleviate the immediate threat facing the FEHB Program--i.e., the large-scale disenrollment of annuitants with Medicare coverage. By making the election of catastrophic coverage under Medicare optional and separate from the other types of Medicare insurance, this proposal would probably have the effect of keeping most Medicare-eligible annuitants in the FEHB Program. (I assume that most annuitants with FEHB coverage would not elect Medicare catastrophic coverage.)

However, I am not able to comment on what kind of impact the Blue Cross/Blue Shield proposal would have on the integrity of the Medicare program or on whether it would be acceptable to those agencies with interests beyond the FEHB Program. I note that the Senate-passed version of the Medicare catastrophic coverage bill includes two amendments that will address the concerns of FEHB enrollees with Medicare coverage.

I hope this is responsive to your question.

Sincerely,

Jean M. Barber

Jean M. Barber
Associate Director
for Retirement and Insurance

Mr. ACKERMAN. John.

Mr. MYERS. Thank you, Mr. Chairman.

As has been mentioned by you and other witnesses, it seems all the premiums are going up. FEHBP is going up 31 percent. Medicare is expected to go up 38.5 percent next year. Why? What is it that causes these premiums to go up? We so often here retirees speak about their COLA's. Their COLA's go up and it seems their premiums then on their health programs go up accordingly the same number of dollars and people often ask this question.

I can't answer it. What is it that really drives these premiums up?

Ms. BARBER. I think there are several levels of answers there. I cannot deal with all the levels. At the first level, the answer is the premiums go up because of the experience of the plans. Our fee-for-service plans are experience-rated. What happened in 1987 is that the cost of paying the claims for medical services was far greater than we had anticipated and than the carriers had anticipated it would be, and we and they now project that those trends will continue.

If you are asking what is going on in the health care economy to drive those trends, that is a very deep question. Most people believe it has to do with an aging population, with advances in technology, with greater demands on the part of the population for medical services, with liability insurance issues, with a whole host of interrelated, very complex problems that drive not only our program but all health insurance programs in the same direction.

Mr. MYERS. I presumed that to be the case, that costs had gone up. Has OPM made any effort to find out why those costs have gone up?

Ms. BARBER. The costs went up because of a number of factors, sir. Inflation, medical inflation, the cost of medical services, is not what it was.

Mr. MYERS. It was not 31 percent.

Ms. BARBER. No. There is a compounding effect—increased utilization, the fact that the base, the 1987 premium, was inadequate and, therefore, you have a notch up to bring that to the appropriate level, and then you project a continuation of that trend. We are at absolute rock bottom in reserves and a program of this size should have some reserves, so you have to have some reserve build-up in there and then we factor in, in our program, because of the multiple choice feature, an amount for adverse selection, for people in the open season looking at the new plans and optimizing their coverage which always costs you more than if everyone were confined to a single group or to a few groups.

Those are the factors and their compounding effect will give you about 31 percent.

Mr. MYERS. It is a sizable increase and it seems difficult to say inflation, expanding, you are providing more medical care for more people, but it still seems rather difficult to imagine how it can grow that rapidly, all these things add up to 31 percent or 38 percent in the case of medicare. I find it very difficult to explain to people. I can't when I am asked.

Ms. BARBER. I share your consternation about it, I do. But the figures are there.

Mr. MYERS. Could you provide briefly some of those figures for the record?

Ms. BARBER. Certainly.

Mr. MYERS. Mr. Chairman, I think it would be interesting if we could see some of these pushing factors that are pushing those rates up. I don't need a volume. If you provide us briefly some of these factors that are contributing to the increase in the premium, we would appreciate it.

[The information follows:]

The 31-percent average increase in FEHB premium rates is attributable to five factors. The table below identifies those five factors and shows their relative impact on the rate increase:

Medical inflation	7%
Increased utilization	4%
Projected open season adverse selection	3%
"Notch-up" or increase to put rates at correct 1987 level	6%
Reserve recovery	8%
Aggregate	31%

Medical inflation measures the increase in the price of medical services used. The 7% rate shown above is consistent with the increase in the medical care component of the CPI during the last year.

Utilization is the number of insured medical services provided to FEHB enrollees. Available claims data for 1987 show an increase in utilization, especially in outpatient services, and we are projecting that utilization will continue to increase in 1988. (The 4% utilization factor assumes no adverse selection during the 1988 open season.)

Adverse selection refers to the optimizing behavior displayed by FEHB enrollees during the annual open season. Because FEHB enrollees try to choose the insurance plan that best covers the medical expenses they expect or plan to incur, after open season many plans end up with a new mix of enrollees who as a group are more likely to incur covered expenses than the previous mix. This causes an additional increase in utilization in the program.

The "notch-up" increase is required because in the 1986 negotiations we underestimated the increase in program costs and utilization for 1987 and thus set the 1987 premium rates too low. A 6% increase was needed just to bring the 1987 premiums to where they should have been. (In effect, the other four factors are applied to the average 1987 premium after it has been adjusted to the correct level.)

The reserve recovery factor represents the increase in rates needed to build up FEHB reserves back up to an appropriate level. Program reserves have been depleted due to inadequate premium levels.

The aggregate increase of 31% results from the compounding of these five factors. (1.07 x 1.04 x 1.03 x 1.06 x 1.08 = 1.31)

Mr. ACKERMAN. Thank you, John. That would be interesting. Ms. Barber, pretend no one else is listening. Pretend everyone else has fallen asleep. Let me ask you a question privately.

Are there too many choices? With 400 plans out there are we operating at a maximum of inefficiency with that many choices? If the choices were fewer or if there were some coordination, greater coordination between these plans or several umbrella groups coordinating these plans, would we be able to get a better handle on these runaway escalating costs that we seem to be faced with? Have we sacrificed efficiency for the benefits of choice?

Ms. BARBER. Well, that is certainly one of the issues that is very high on our list of things to be studied in the comprehensive evaluation I spoke about. We have a suspicion in that direction, I would have to say. We also note that as our program grows by 50 to a hundred new choices a year, we are reaching the limits of the enrollee's ability to deal with the amount of information, to absorb the amount of information required and to make an intelligent choice.

So there is in our own minds a very serious question about whether we have not perhaps gone beyond the bounds of the reasonable in the matter of choice.

Mr. ACKERMAN. We would be interested in seeing some of the conclusions you might reach after looking at some of the numbers as well. We thank you very much for being with us today and for your testimony.

Our next witness will be H.T. Morrissey, president of the National Association of Retired Federal Employees. Please introduce to us those joining you at the witness table.

STATEMENT OF H.T. "STEVE" MORRISSEY, PRESIDENT, NATIONAL ASSOCIATION OF RETIRED FEDERAL EMPLOYEES, ACCOMPANIED BY GORDON BROWN, NATIONAL SECRETARY, AND JUDITH PARK, LEGISLATIVE DIRECTOR

Mr. MORRISSEY. Good morning, Mr. Chairman, members and staff of this committee. On my left is our national secretary, Mr. Gordon Brown, who is a retired assistant director from the OPM's Health Insurance Department. He is also a recognized expert in the Federal employees health benefits area.

On my right is our legislative director, Judith Park.

Mr. MORRISSEY. Mr. Chairman, members of the subcommittee, I am Steve Morrissey of the National Association of Retired Federal Employees, otherwise known as NARFE. I speak for more than 1.9 million civil service retirees, including NARFE members.

Today, we address this catastrophic legislation in terms of its adverse impact on the Federal annuitant. Prior to that, I would like to point out that we in NARFE have been voicing concern about the continued vulnerability of the elderly to the real health care catastrophe, which is long-term custodial care and the concept of basing medicare premiums on taxable income.

What we have here with the House plan and also that before the Senate is a plan that provides catastrophic coverage identical to that which most Federal annuitants already have through FEHB

at a cost exceeding what other Medicare-eligible retirees at an identical income level would have to pay.

That, Mr. Chairman, is a bad buy. We should not even be asked to support legislation that is so patently unfair to those who chose to spend their careers in government service.

Let me first address the issue of premium inequity in this bill.

Once again, Federal retirees are faced with what amounts to a new tax. In just the past year, civil service retiress have been constantly jerked about by tax changes which have thrown earlier financial plans totally out of kilter. They have been stunned by the retroactive elimination of the tax code's 3-year rule, then surprised by taxation of their new lump sum annuity option, and now this—an income-based premium for catastrophic health insurance protection that will be imposed through the Federal income tax structure.

The inequity in premium computation in this bill results partially from the long-standing difference in tax treatment between social security and civil service retirement income. This basic difference in the tax treatment of those two sources of Government retirement benefits results in major differences in supplemental premiums at identical levels under this legislation.

In the case of a civil service annuitant with an income of $15,000 a year, H.R. 2941 would impose a supplemental premium of $580 in 1988. The private sector retiree with the identical income would pay a supplemental premium of only $210.

Here are two individuals with identical incomes paying for identical insurance coverage, yet the Federal retiree would be required to pay more than twice more.

Under the House-passed bill, this retiree would have no choice for it makes this new coverage mandatory for all individuals who are Medicare-eligible.

The Federal annuitant will see no appreciable change in health care benefits. Yet he will pay an additional tax to the Federal Government that exceeds that required by other Medicare-eligible individuals.

This is contrary to basic principles of fairness and equity. We believe that the best solution to the problem is enactment of legislation to treat Federal pensions the same as social security for tax purposes.

Short of this, an adjustment factor is needed in the calculation in the supplemental premium so that those with public sector retirement annuities will not pay more than others at identical income levels.

This would reduce the extra tax burden, however, these individuals would still be paying twice for the same benefits. It is crucial that both problems be addressed and solved for this legislation to impact in a fair manner.

And, there are other factors that are relevant to the premium inequity in this legislation. Federal workers retiring at age 65 who choose to take the lump sum option will find that payment calculated into their adjusted gross income and their Medicare supplemental premium as well.

The Government pension offset and windfall reduction formula which result in total elimination or major reduction in social secu-

rity cash benefits to which a Federal retiree might be entitled, also impact this calculation.

This is tax-preferred income that they are losing. All of these factors further compound the already-known premium inequity imposed on the Federal annuitant under this legislation.

There are an estimated 1.2 million Federal retirees and survivors over 65 who immediately stand to be unfairly impacted. And these are not wealthy people. As of last October, the average retiree annuity was $13,566 and the average survivor's annuity was only $6,432 per year.

Mr. Chairman, in very real terms, the burden this legislation would impose on these people is weighty and they are afraid. The past few weeks have brought news of skyrocketing premiums under both FEHB and Medicare Part B, before addition of any catastrophic benefits.

FEHB rates will increase an average of 30 percent. Medicare Part B rates are estimated to rise from $17.90 to $24.80 a month next year. The costs of the new Medicare catastrophic expansion are revised upwards at every turn.

What is particularly frightening is that we are dealing with estimates, conservative estimates. Congress' own General Accounting Office, as well as the Congressional Budget Office, have voiced serious reservations over the out-year costs that could be imposed on annuitants. We also find alarming their findings that at currently anticipated premium levels, the average value of new benefits to be received exceeds new premiums required only for those in the lowest income brackets.

In its July 30 report comparing the catastrophic proposals before Congress, CBO states that the House-passed bill would provide an average new benefit to enrollees in 1989 of $226 per year. At the same time, the legislation would cost that same average enrollee $232, more than he stands to receive in new benefits.

We urge Congress to slow down and review the information contained in these reports before imposing new benefits and new costs on the elderly that they may not want, may not need, and may very well not be able to afford.

We hope Congress will study the new costs that will be imposed on the elderly with the same zeal that it would employ if the costs of this Medicare expansion were to be borne by the Federal Treasury.

As we all know, this legislation is designed to be self-financed with elderly beneficiaries bearing the costs of benefit improvements. I am sure we all agree that this necessitates an especially hard and long look toward what the future holds.

And, as we pointed out earlier, most Federal annuitants, like millions of other retirees, have no need for this coverage. Seventy-eight percent of all Federal retirees continue their participation in the Federal Employees Health Benefits Program. Those who are Medicare-eligible do so to fill the gaps in their Medicare coverage.

With the combination of these two programs, the Federal retiree is able to protect himself quite nicely against most health care costs. There are few instances where the proposed legislation would offer superior coverage to that which these annuitants already enjoy.

And FEHB benefits are not cheap. The average single Federal retiree with Standard Option Blue Cross-Blue Shield will pay $29.75 per month for that coverage next year, a 60-percent increase over what that same plan cost him in 1987.

This is the type of FEHB plan coverage that the majority of Federal annuitants use and find acceptable as a Medicare supplemental policy. As you know, while both S. 1127 and H.R. 2941 give private MediGap policies a defined period of time to adjust their benefit and premium structure so as not to duplicate the new and expanded Medicare coverage, this charge is not extended to employer-sponsored health insurance such as the FEHB plans.

The Office of Personnel Management, Federal and Postal employee and retiree organizations, the FEHB health care providers, all have appealed to Congress for coordination of benefits between FEHB and Medicare before the new expanded catastrophic benefit package is signed into law.

In fact, Blue Cross has estimated that if there is no coordination, the additional cost to Federal annuitants alone could exceed $100 million in 1989.

If the mandatory nature of this legislation prevails, and if Federal annuitants are faced with paying both FEHB premiums and the new Part B and supplemental Medicare costs, they may have no choice but to drop one or the other, or pay for duplicate benefits.

These are the only options: One, pay for both even though you don't need both; or, two, opt out of Medicare entirely, which some annuitants would be able to do; or, three, opt out of FEHB, which provides them with the best coverage and which represents a benefit that is part of their total retirement package, a choice they should not have to make.

These are not real choices, nor are they solutions. Furthermore, by making this new coverage mandatory for Medicare-eligible annuitants, we are removing a choice only they are equipped to make: Which health plan provides the best coverage?

It is ironic that this situation could actually have the unintended effect of creating a group of people with less health care coverage than they have now. In most cases, if a person is forced to drop his FEHB coverage to pay for his mandatory catastrophic Medicare benefits, that individual will be less well covered for health care costs than he was before this catastrophic debate began.

Even the Office of Personnel Management has stated that the new supplemental premiums will make it extremely burdensome for Federal retirees to carry both coverages. And, if there is no modification of this duplication of benefits, massive withdrawal of Medicare annuitants from the FEHB program could occur.

This could very well throw the entire program into turmoil with substantial premium increases for those that remain behind and may even threaten the viability of some of the health insurance carriers participating in that program.

While this is no one's intent, it is nonetheless a reality. As currently written, the FEHB program lacks the flexibility to recognize this duplication and act to correct it. If we do not come up with a satisfactory solution to these problems for the Medicare-eligible Federal annuitant, everyone stands to lose, the Government as employer, the employees and the annuitants.

If sizable numbers of Federal annuitants leave the FEHB program, costs for those remaining will rise. Because the Government pays between 60 and 75 percent of the costs it, too, will pay substantially more.

On the other hand, should large numbers of Federal annuitants opt out of Medicare in an optional plan such as that contained in the Senate version of this legislation, premiums for those who remain in the Medicare system will rise sharply.

It is to everyone's advantage to address and find workable answers to the problems inherent in this legislation. There are no clear-cut remedies or especially attractive options for fixing this. Each solution seems to beget another problem.

However, one thing is clear. Simply shifting payment for certain catastrophic expenses from FEHB to Medicare and requiring Federal annuitants to pay twice for the same coverage is not the solution.

We believe giving Federal retirees the option of not participating in the new expanded Medicare coverage is worth considering. The current Part B interacts well with the FEHB program. Given all the ramifications of changing the current interaction between these two programs, allowing these retirees to retain the current mix of benefits is something that Congress should explore.

Another possible solution is to instruct OPM to study the impact of FEHB offering differing levels of coverage, including a Medicare supplemental option. Such a study could provide the answers we are seeking and it certainly seems that OPM is in the best position to know what will and will not work without creating unnecessary havoc within FEHB.

We appreciate the attention you have focused on these problems, and we hope that you will work toward passing legislation insuring that no elderly taxpayer is charged more for Medicare protection than another with identical income simply because of the source of tax treatment of their income. Modification and coordination of FEHB with any expanded Medicare package is equally imperative. To correct one and not the other is no real solution.

Thank you again. My staff and I look forward to working with you to resolve the issues that have been raised here today. I would be happy to answer any questions the committee may have.

[The following correspondence was received for the record.]

NATIONAL ASSOC. OF RETIRED
FEDERAL EMPLOYEES
1533 NEW HAMPSHIRE AVE., N.W.
WASHINGTON, DC 20036

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OCTOBER 2, 1987

THE HONORABLE GARY L. ACKERMAN
1725 LONGWORTH HOUSE OFFICE BUILDING
WASHINGTON, DC 20515

DEAR CONGRESSMAN ACKERMAN:

MEETING IN NATIONAL CONFERENCE IN ST. LOUIS, MISSOURI ON SEPTEMBER 30, 1987, THE NATIONAL EXECUTIVE BOARD AND FIFTY STATE FEDERATION PRESIDENTS OF THE NATIONAL ASSOCIATION OF RETIRED FEDERAL EMPLOYEES, REPRESENTING SOME HALF A MILLION NARFE MEMBERS, EXPRESSED THEIR DEEP CONCERN REGARDING PASSAGE OF THE PENDING CATASTROPHIC HEALTH CARE BILL. IT IS BELIEVED THAT THIS LEGISLATION WILL RESULT IN CONSIDERABLE NEW TAXES FOR MILLIONS OF ANNUITANTS WITHOUT MEETING THEIR NEEDS NOR ADDRESSING THEIR REAL CONCERN -- LONG TERM NURSING HOME AND HOME HEALTH CARE COSTS. YOUR EFFORTS TO HELP CORRECT THESE INEQUITIES WILL BE APPRECIATED.

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THE HONORABLE GARY L. ACKERMAN
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Mr. ACKERMAN. Thank you very much.

First, let me begin by commending you and NARFE for your efforts to educate retirees. A large group came to my office last week to educate me. The lobbying efforts, I think, have been very, very extensive and very well-organized.

We have received many calls and letters, as I know other Members of Congress have. We do appreciate hearing from you and your members and hearing your perspective. It is very important to us as we continue these deliberations.

If we make the assumption that H.R. 2470 is going to prevail in the Congress and get signed into law, would you be able to speculate on what the average NARFE members would be doing? Would they drop out of FEHP? What do you think they would do?

Mr. MORRISSEY. Mr. Chairman, if this legislation passes as presently constituted, I would recommend to the members of my Association that they drop out. I recognize that they would never be able to get back in.

Mr. ACKERMAN. You would recommend that they exercise the irrevocable option and drop out?

Mr. MORRISSEY. Yes, sir.

Mr. ACKERMAN. If others follow that same course, what would you think the results would be on those plans?

Mr. MORRISSEY. It would place the system we now have in somewhat of a turmoil because those that remained in the system would have to bear the additional costs more so.

Mr. ACKERMAN. Have you considered any of the other solutions that have been proposed, the government retirement or repaying carriers for additional benefits?

Mr. MORRISSEY. I would like to turn that question over to Mr. Brown.

Mr. BROWN. So far as the second option is concerned, returning money to the carriers to provide additional benefits, I don't think I would favor that one. I would prefer that some method be worked out to return some of the money directly to annuitants or to OPM so they can return it to them or to the carrier with instructions that they reduce premiums rather than add benefits.

We are facing tremendous premium increases. Some of these increases have presented us with premiums that many of our members can't afford anymore. I would rather see a reduction in the premiums they now have.

Mr. ACKERMAN. Let me ask the same type of questions I asked before. Are there too many choices?

Mr. BROWN. I think there have been too many choices for many years. If you think, sir, that young, intelligent people such as yourselves have difficulty making decisions every open season, consider what is happening to some of our members. Consider the prospects of an 85-year-old widow or widower who has never worked for the Federal Government or had decisions to make regarding health insurance and throw at them the variety of choices, most of them are making blind choices, or most of them are sticking with the plan they have had for the last 20 years.

Yes, sir, I think there are far too many plans. If I may add a note, in 1957 and 1958, while an employee of the old Civil Service Commission, I worked on a task force which was trying to develop

a voluntary contributory health plan for Federal workers and annuitants.

We were working on one plan rather than the variety we now have. I will tell you, sir, that proposal looks better to me as we go into the program we now have.

Mr. ACKERMAN. You mentioned one plan as a better option of the ever-growing number of choices we have now. Is there no middle ground? Do we have to, for maximum efficiency, avoid all choices? Could there not be possibly a suggestion that there be six or eight or 14 or 9 or some finite number of plans or a coordinated group of plans that may want to voluntarily associate themselves to provide coverage?

Mr. BROWN. Any reduced number would be an improvement, but I would hope for a reduction far below the 400 plans we now have.

Mr. ACKERMAN. I couldn't help but smile when you referred to some of your members not being able to make decisive choices as compared to some of us who might, as you phrase it, be young and fairly intelligent.

Let me just comment that some of those frail, elderly, indecisive, possibly confused people, as you describe them, are among the best-organized, powerful lobbying groups I have ever seen in this country, and are able to push some of us strong, young types around almost at their wish and whim.

Mr. Myers?

Mr. MYERS. I was basking in your remarks. I hope you meant the whole committee being young. I still have my members in NARFE.

Mrs. MORELLA. I have read your testimony and statements, Mr. Morrissey. I wonder if you have had a chance to read the statements that are going to be presented by those who are following you.

Mr. MORRISSEY. No, I have not.

Mrs. MORELLA. I hope you will be available for some response to the suggestions they may offer. I hope you can let us know what the pros and cons might be. I understand that all the new benefits might be put into a Part C option.

Would you like to comment on that?

Mr. MORRISSEY. Yes, ma'am. I would like to go back to the original question. My staff has picked up a copy of the testimony of each witness. We will follow it, and it will be our privilege to go over those and address each of them for this committee.

I believe when the matter of catastrophic coverage was first brought seriously to this location, many of us mentioned a possible subsection C. That seemed to die and fall by the wayside. I have not seen the document offered earlier.

We will be happy to comment when I understand it better.

Mrs. MORELLA. I appreciate that. I look forward to getting your responses to all the pros and cons that will be offered. I think this is an excellent way to come together. Thank you.

Mr. ACKERMAN. Let me, on behalf of the committee, thank you, Steve, for your testimony and your hard work. Thanks for being with us this morning.

Mr. MORRISSEY. Thank you, sir.

[The following information was furnished:]

Aside from the Blue Cross and Blue Shield Association proposal for changes in the Catastrophic Care Legislation, a review of suggestions presented by other witnesses at the October 7th hearing of the House Subcommittee on Compensation and Employee Benefits, are also addressed in NARFE's own statement.

Regarding the proposed modification in the Medicare catastrophic care bills submitted by Blue Cross/Blue Shield, NARFE believes the concept of the proposal is certainly an improvement over the legislation passed by the House, and that reported by the Senate Finance Committee last summer. We support the idea of having the new catastrophic coverage optional instead of mandatory, in a new option such as a Part C.

The BC/BS proposal would have all Medicare enrollees bear part of the cost of the optional Part C catastrophic coverage via an across-the-board increase of approximately $4 per month for Part B premiums. Only those who elected the Part C catastrophic coverage would incur a supplemental premiums for that coverage, and those would be less than the current premium increases being cited.

We view the BC/BS proposal as a combination of the original proposal advanced by the Administration and a plan introduced by Congressman Claude Pepper for a new Part C of Medicare. At least under the suggested proposal, Medicare enrollees would have the option of taking the catastrophic coverage and paying according to tax category, not be forced into such coverage and additional cost.

As with any initial or first-draft proposal, there are still a number of questions about the implications and applications of it. Such as: How would the additional $4 cost for Part B be controlled for future years? Could it be controlled? Would an additional $4 be adequate for Part B and still make a Part C affordable for those who needed it? And perhaps most importantly, what kind of reorganization of the FEHB Program is seen as necessary? These and other details would have to be set forth and reviewed before NARFE could give support to the BC/BS proposal, but we do applaud the concept involved as an effort to correct what is currently a bad bill and a bad buy for Federal retirees and millions of others.

Mr. ACKERMAN. We are happy to have as our next witness before the subcommittee a distinguished leader and also native New Yorker, Mr. Moe Biller, President of the American Postal Workers Union. Please introduce your associates.

STATEMENT OF MOE BILLER, PRESIDENT, AMERICAN POSTAL WORKERS UNION, ACCOMPANIED BY PATRICK NILAN, LEGISLATIVE DIRECTOR, APWU, AFL-CIO AND DAN BRANDEBERRY, DEPUTY PLAN MANAGER, APWU HEALTH PLAN

Mr. BILLER. Thank you.

I am Moe Biller, representing the Postal Workers, AFL-CIO. With me today are Patrick Nilan, legislative director, APWU, AFL-CIO; and Dan Brandeberry, deputy plan manager, APWU Health Plan. I am going to try to help you folks. I will subscribe to all of what Mr. Morrissey stated. Just to repeat, the figures he handed you are very important, particularly pointing out the unfairness of a retired Federal worker in the same pay bracket as a retired worker from the private sector having to pay $580 compared to $210 a year for the new program.

I wish to state at the outset that the American Postal Workers Union understands very well what has motivated the Congress to propose legislation to improve the benefits provided to this Nation's Medicare recipients.

We understand and support your efforts to address the cost of the health services required by this Nation's 33 million Medicare eligibles, and to establish mechanisms to examine ways to improve comprehensive health care services to all Americans.

There is obviously a crisis in health care in this Nation. The cost of health care is escalating beyond the grasp of even the working population in this country, let alone beyond the reach of this Nation's retirees.

Since 1965, when the medicare program was established, the Medicare-eligible population's percentage of income which is dedicated to health care will have risen from 15 percent to a projected 18.5 percent by 1991. At the same time, constraints on the Federal budget have resulted in reductions in the medicare program.

In 1983, the Social Security Act Amendments funneled a vast new infusion of funds into the Medicare Hospital Insurance trust funds, while at the same time mandating that Postal and Federal workers pay 1.3 percent of salary into the Medicare Hospital Insurance Trust Fund.

Despite the additional funding provided by the 1983 amendments, or perhaps because of the additional funding, Congress began to reduce funding for medicare services in 1986 through a series of proposals which were enacted using the budget process.

As a result, as late as this past September 30, the Health Care Financing Administration announced that a new round of Medicare premium increases will be necessary to keep the H.I. Trust Funds balanced.

Under H.R. 2470, as passed by the House, the new catastrophic insurance coverage is extended through Part A, the Medicare hospital insurance fund, which is made mandatory for all Medicare enrollees. To finance these benefits, the bill imposes an income-re-

lated supplemental premium on Medicare participants. This premium would range from $10 to $580 per beneficiary in 1988 to $930 per beneficiary and $1916 per couple by 1992.

H.R. 2470 also mandates increases in the optional Part B premium of $1 per month in 1988, followed by additional increases of $1.50 per month in both 1991 and 1992.

Under the Senate version of the legislation, S. 1127, only Medicare-eligible individuals who elect to enroll in the Medicare Part B supplemental medical insurance program will be liable for the House-mandated increases in the regular Part B premium and for the new supplemental premium which finances the catastrophic insurance provisions.

Under both of the bills, the new supplemental premium is calculated using either adjusted gross income or income tax liability to determine the Medicare beneficiaries' premium liability. Because of the tax treatment of income derived from Federal pensions, Postal and Federal retirees will be subject to much higher supplemental premiums.

Federal pensions, as the subcommittee is well aware, are fully taxable from the first dollar. Under the pending legislation, civil service retirees would be liable for the increased supplemental premium to a greater degree than their social security counterparts.

It was only in 1983 that Congress first imposed any measure of tax liability on social security beneficiaries, and even that liability is limited to those with income exceeding $25,000 and $32,000 for individuals and couples.

As a result, under this proposed legislation, Postal and Federal retirees, who are Medicare-eligible, will suffer a vastly increased tax liability in order to finance Medicare catastrophic illness benefits which are currently available through their health insurance plans.

The American Postal Workers Union Health Benefits Plan has over 40,300 enrollees who are Medicare-eligible. When we analyzed and compared the benefits proposed under H.R. 2470 with the benefits presently provided to our Medicare-eligible health plan enrollees, we found that there are few, if any, instances where the proposed legislation provides superior coverage.

It is shameful that a great idea like this, which will benefit the entire population, once again treats Postal and Government workers unfairly.

Given that the premiums and coverage established by this legislation will be imposed mandatorily on most Medicare eligibles, including those enrolled in the American Postal Workers Union Health Benefits Plan, our retired members will be faced with untenable options if this legislation is enacted.

Either they must bear the burden of paying both their FEHB premium and the supplemental catastrophic premium or they will be forced, for economic considerations, to abandon their union-sponsored health insurance program for a Government-sponsored program with inferior benefits. That election, once made, is irrevocable, as you know.

As you heard from NARFE and you will hear from other organizations, what this could possibly do, too, is make a big drain on the

FEHB program, which would result in skyrocketing premiums and more confusion in the FEHB program itself.

Mr. Chairman, I am not here to debate the merits of catastrophic insurance legislation or to argue whether or not this legislation is good public policy. I am here to voice APWU's opposition to the method of financing this legislation and the inequitable, additional tax burden it imposes on our retired membership, and on all active workers who were forced into the social security program by congressional action in 1983.

The social security benefit formula was designed to be weighted to the advantage of lower-income workers, and as such, the formula replaces a greater share of the pre-retirement income of lower-income workers.

We find it ironic that the social security program's health insurance component, Medicare, would, if this legislation is enacted, create an additional tax burden on Postal and Federal retirees whose average annuity is about $13,000 per year. I think the Congress recognizes very well that in any type of budget crisis threre is always the one group that is unfairly treated. It happens in this case, to be Postal and Federal retirees.

I don't think this is deliberate, but it seems like when somebody has to be skinned, it is us. I think it is time to end that.

We believe that it is incumbent upon the Congress to find a solution to the Medicare catastrophic insurance financing problem which does not impose an additional burden on Postal and Federal retirees. A solution which we favor would be for the Congress or the Office of Personnel Management to establish a separate supplemental premium schedule for Postal and Federal Retirees who are Medicare-eligible.

This schedule should recognize the disparate tax treatment of Federal pensions, and adjust the supplemental premium schedule so that Postal and Federal retirees are not paying higher premiums than their counterparts whose pension benefits are not taxable.

When we testified before the Senate Governmental Affairs Committee on September 23, 1987 regarding our position on S. 1127, we submitted to the committee a draft amendment which directs the Office of Personnel Management to craft such a schedule.

Recognizing that the House has already passed this legislation, we will submit for your consideration our proposed amendment to the Senate bill and ask that it be made a part of the record of this hearing.

We would, of course, be pleased to work with the members of the subcommittee to tailor this amendment to any conference vehicle, should the Medicare catastrophic insurance proposal pass the Senate.

This concludes my statement, Mr. Chairman. I would be happy to respond to any questions which the subcommittee may have.

[The proposed amendment follows:]

(APWU Proposed Amendment Language is Underlined)

SEC. 6. SUPPLEMENTAL PREMIUM FOR CATASTROPHIC ILLNESS COVERAGE.

(a) IN GENERAL.--Part B of title XVIII is amended by inserting after section 1839 the following:

"SUPPLEMENTAL PREMIUM FOR INDIVIDUALS COVERED BY PART B

"SEC. 1839A. (a)(1) Any individual described in paragraph (2) shall pay the applicable supplemental premium in the manner provided in subsection (c).

"(2) An individual is described in this paragraph if such individual--

"(A) is covered by the insurance program established under this part for any portion of any taxable year occurring after December 31, 1987, and

"(B) has Federal income tax liability for such taxable year in an amount not less than $150, <u>which does not include federal retirement income</u>;

"(b) For purposes of this section--

"(1) The term 'applicable supplemental premium' means an amount equal to the product of--

"(A) the number of months in the taxable year during which the individual was covered by the insurance program established under this part, multiplied by

"(B) the supplemental premium.

"(2)(A) The term 'supplemental premium' means an amount equal to the product of--

"(i) the premium rate for the taxable year, multiplied by

(ii) the amount determined by dividing--

"(I) For individuals deriving no income from a federal annuity, the individual's Federal income tax liability for such taxable year, by

"(II) $150.

"(iii) or, for individuals whose income is derived in whole or part from a federal annuity,

(I) the individual's Federal Income Tax liability for such taxable year, by

(II) an amount to be determined by the Director of the Office of Personnel Management which makes an equitable adjustment for the differences in tax treatment of social security and federal annuity income.

If any amount determined under clause (ii) is not a whole number, such amount shall be rounded to the next lowest whole number.

[Alternatively, §(iii)(II) could read $200.00]

Mr. ACKERMAN. Moe, thank you very much for that very concise presentation, as well as your full statement, which will be part of the record.

Would you be able to tell us how many of your members fit into the retiree category?

Mr. BILLER. Some 25 percent, 56,748.

Mr. ACKERMAN. Over 56,000?

Mr. BILLER. That is correct. And we don't complain about the burden we have in carrying the elderly and retirees. They have done their job for the Federal Government for a lifetime.

Mr. ACKERMAN. Making the presumption that may or may not be premature that the Hobson's choice, as you so aptly phrased it, might be inevitable, that the bill survive the conference as is, and that reason does not prevail, what would be your advice to those 56,000-plus members who would have to be faced with that untenable choice?

Mr. BILLER. That would give me a Hobson's Choice, too, but I would have to tell them in their own interest, and it is a terrible thing to tell them, drop out of our plan.

I was in a similar situation, in 1981 when it was essential for me to get under Medicare and being the first year there was a 10-percent penalty. I don't know what this situation will do. Either way, our retired members are going to be in trouble.

As I pointed out, the other organizations may have to tell their members the same. In fact, I am not sure that the members will even ask, they are going to see that they have no choice, and they are going to be in great difficulty. These members will play off on the FEHB program, which had plenty of problems before.

Mr. ACKERMAN. We are trying to do an unofficial, nonscientific survey to see what kinds of trouble the system might be in if that advice is going to be consistent.

Mr. BILLER. Imagine me as the president even having to do that. It is just terrible. I don't think this is a matter of crocodile tears. I think when we get through, the Congress will recognize, in my opinion, that we do have a problem. The issue is one of fairness and nothing else.

Mr. ACKERMAN. Let me ask the same question I asked of other people with nobody else listening. Are there too many choices among the plans? If we narrowed it to six or so plans, would that create a more cost-efficient system or would people resent the fact that they are almost unlimited amount of choices was gone?

Mr. BILLER. I would not know as a nonprofessional in this area how many to put it down to, but we have over 400 plans. Let's face it, I don't really believe people know what to pick and they probably narrow down to who gets to them first or whatever. I think anybody can tell you that 400 opportunities is no longer competition, it is anarchy. I think recent experience with FEHB is proving that.

Mr. ACKERMAN. Thank you very, very much. Are there any questions?

Mr. MYERS. I have no questions.

Mr. ACKERMAN. Ms. Morella?

Mrs. MORELLA. It seems to me from your testimony, as well as looking at the amendment you offered to the bill on the Senate

side, that what you are addressing is the disparate treatment between the Federal annuitant and the social security recipient?

Mr. BILLER. Absolutely.

Mrs. MORELLA. I agree with you. I think we all do. There was something you didn't seem to address in an amendment, and maybe that is because we have not found the solution yet. That is the duplication of coverage. Is that not also a major problem?

Mr. BILLER. I think I addressed it when I pointed out that there are two coverages here and only one is necessary.

Mrs. MORELLA. Does your amendment address it?

Mr. BILLER. The amendment did not address it but we can reexamine that and see if we can improve it.

Mrs. MORELLA. Again, we do look forward to also getting your response to each one of the recommendations that have been offered and that will be offered. Then, picking up on a question that the chairman asked, let's just say that the Congress does not make the appropriate adjustments in this bill—I think they will—but if they do not, what would your recommendation to your congressperson be, to vote against the bill if it remained in that state?

Mr. BILLER. It may sound like a hedge. I would have to say I will cross that bridge when I get there or close to it. First of all, I don't know how anybody could disagree with the concept of the need for catastrophic health insurance in this case. It is absolutely essential. When OPM compelled all the FEHB carriers to get catastrophic insurance, they may have understood this legislation was inevitable and didn't want the FEHB program to be done in.

We will have to make the decision about supporting the legislation and it is a really rough decision because the concept of this type of social legislation is one that has been long needed in this nation.

Mrs. MORELLA. I can understand why you are in a leadership position, because that is a very good political answer.

Mr. NILAN. Really, it is the concept we are talking about. There have been no alternatives. It is obviously a very difficult area to try to legislate in, particularly since we share the views of Congressman Hoyer that the Ways and Means Committee has made it very difficult for Federal retirees in middle brackets.

The amendment is only a concept and you will note we accent the changes only. Senator Pryor asked me when we testified a couple of weeks ago if this wasn't a back door approach to the Ways and Means financing mechanism. I said you have it exactly correct. We are trying to show the discriminatory treatment of those under Federal retirement vis-a-vis those under Social Security.

We are asking equality and it is difficult to get from Ways and Means these days.

Mrs. MORELLA. I understand. Thank you for the equal treatment that you gave in the newsletter.

Mr. NILAN. I might state, if this legislation should become law, we are going to be back to see a lot of you next year before the bill goes through to try to get an amendment.

Mr. BILLER. Our chairman does not control the entire Congress of the United States, but I do have total confidence that he, as well as

those of you who are here, understand what we are talking about and will try to do everything you can. We hope so.

Mrs. MORELLA. We would not have the hearing if we did not fully commit to that. Thank you.

Mr. ACKERMAN. Mr. Myers has a question.

Mr. MYERS. I have a question to make sure I understand what you said this morning here. You said that if this bill that is in the Senate now became law, that you would advise your membership to not carry the FEHBP; is that correct?

Mr. BILLER. I would have to say that.

Mr. MYERS. I thought you said to Mrs. Morella that if the bill comes back in its present form you could not tell members not to vote for it. You are giving me a dilemma. You are not going to say vote against it. I can't understand that reasoning. Could you explain why?

Mr. BILLER. I am not comprehending yet what you have raised. Would you repeat it again? I said if this legislation passed, I would have to tell our people to get out of the FEHB program, as distasteful as that recommendation would be. Did you ask whether ultimately we will ask our members to vote?

Mr. MYERS. Yes.

Mr. BILLER. I said I had not made that decision because of the importance of the legislation. I will have to cross that bridge close to that time. I know it sounds like a contradiction.

Mr. MYERS. It sure does to me. Thank you.

Mr. ACKERMAN. The committee appreciates your sharing your thoughts and opinions once again.

Mr. MYERS. I voted against it in the House because I was concerned about the issues brought up this morning.

Mr. BILLER. That is all right. I will commend you for it. All I am trying to say is, while our interests are very much at stake, we are not looking to destroy legislation that will benefit the rest of the population.

What we don't want to do is get hurt here and be treated unfairly.

Mr. ACKERMAN. If I may, just to clarify and sort the puzzle out, I think what you are suggesting, Mr. Biller, is that you will cross the bridge when you come to it as to whether or not the legislation, when finally passed, should be recommended to your members and their representatives as being worthy of voting for it.

Mr. BILLER. That is right.

Mr. ACKERMAN. At the same time, if the legislation passes and double coverage is still on the books, that you would make the recommendation to your members at that point that they drop out FEHBP.

Mr. BILLER. Absolutely.

Mr. ACKERMAN. An irrevocable decision.

Mr. BILLER. Right. I can certainly tell you that in going into conference, we will be lobbying for fair and equal treatment. We will not say, "Take the bill as it is." We don't want it that way.

Mr. MYERS. We are all certainly hopeful that something can be improved in that conference. I don't see it coming yet, but I hope it can.

Mr. BILLER. If it can't, we will have a major problem.

Mr. MYERS. Cross that bridge when you get there, okay.

Mr. BILLER. If the bridge doesn't fall. Congress will hear from us, I assure you.

Mr. MYERS. We always have.

Mr. BILLER. If you voted against the bill for this reason, I want to commend you and I appreciate it.

Mr. ACKERMAN. Thank you very much for being with us this morning.

Next we are privileged to have with us a panel consisting of Frank Conners, executive vice president of the National Association of Letter Carriers; and Donald J. Kaniewski, legislative director, Mail Handlers Division, Laborers International Union of North America.

STATEMENTS OF FRANK CONNERS, EXECUTIVE VICE PRESIDENT, NATIONAL ASSOCIATION OF LETTER CARRIERS AND DONALD J. KANIEWSKI, LEGISLATIVE DIRECTOR, MAIL HANDLERS DIVISION, LABORERS INTERNATIONAL UNION OF NORTH AMERICA

Mr. KANIEWSKI. Accompanying me this morning is Jack Wells, a representative of the CNA Insurance Co., the underwriter.

Mr. CONNERS. My name is Frank Conners, executive vice president of National Association of Letter Carriers and on my right is George Gould of our organization.

Mr. ACKERMAN. Frank, would you begin?

Mr. CONNERS. Mr. Chairman, I have a statement for the record which I will read.

Mr. CONNERS. The NALC firmly believes in catastrophic health care, soaring health costs and the potential impoverishment of the elderly are grievous problems. We believe so strongly in the need for catastrophic health coverage that we worked with the AFL–CIO for passage of legislation, as did other members of FAIR, the Postal/Federal coalition.

Mr. Chairman, these are very timely hearings for public employees—and anyone else who bargains for health benefits. They are unduly harmed by this bill. So thank you for this hearing, establishing testimony for the record and moving toward a solution.

Background on NALC Health Plan: Let me explain a little about our plan. The NALC Health Benefit Plan has been in existence since 1950, when it was established to provide health coverage to its membership. Today, we process in excess of 150,000 claims each month, and pay out approximately $40 million in monthly benefits.

We are not an insurance company per se; that is, we do not take a profit. All payments are returned as benefits, minus operating costs. Therefore, there is nothing self-serving about this testimony. We are here to represent our enrollees, because we know what their needs are.

Our program is based on "cradle to grave" coverage. In other words, 21-year-old letter carriers are charged the same premium amount, and receive the same coverage, as retired letter carriers. As with any insurance program, our premiums are based on the statistical data for this entire, diverse population in which the

younger members generally use fewer benefits than the older members.

In the case of annuitants, our coverage carries out the spirit of the 1966 Federal Employee Health Benefit Act and Medicare: 100 percent coverage, using Medicare as a supplement.

Incidentally, in 1966 our plan coordinated with Medicare as a full, 100 percent coverage plan. Many others did not. OPM strongly urged all FEHBP contractors to follow our example, something for which we testified often. Consequently, our plan's premiums have remained relatively constant, responding mainly to inflation and health costs increases. In the intervening years, almost all plans now mirror the NALC.

In 1986 the NALC plan provided almost one-half billion dollars to its enrollees; that sum will be exceeded in 1987. Of that amount, we returned $181 million to our annuitant enrollees, who represent 34 percent of the total enrolled population. In most cases, statistics show that annuitants covered by both Medicare and the NALC plan received 100 percent of covered charges.

Effects of H.R. 2470: If annuitants find that they cannot afford both Medicare and the NALC plan, we're afraid they'll opt for the cheaper and less expensive coverage I Medicare. Our plan cannot afford to lose that group of enrollees, because when that happens the premiums become volatile. Our statistics show that the premiums would soar. Nor do I think the country wants to enlarge its sector of undercovered elderly.

It runs contrary to decent health policy, and means H.R. 2470 would have the unintended negative effect of creating more people with less coverage. Furthermore, passing the buck back to Medicare will have two adverse monetary effects: (1) raise the dollars needed from Congress to cover the elderly Federal/postal population who discontinue FEHBP, and (2) raise the premiums all plans must charge the remaining enrollees. That also will cost the Government more because the Government provides a 60 percent copayment, based on the average of the "Big Six" plans.

While we believe in catastrophic care, we believe that Congress should aim its bill at those who need it. Quite frankly, H.R. 2470 would not significantly help retired letter carriers, or any other workers who bargain for health benefits. There are many other unions in a similar position. Our retirees are put in the unfair position of paying a tax, which may increase dramatically in a short period of time for nothing.

I say nothing because in most cases H.R. 2470 and Medicare parts A and B offer less coverage than the federal employee health plans. For example, someone with both Medicare and NALC's plan receives 100 percent of drug bills. Someone with just Medicare would have a deductible of at least $500, according to the current proposals. That also is true in varying degrees for hospital care, home visits and other necessary health care items.

Under the current proposal, an annuitant earning $20,000 would pay $611 for no additional benefits. That's a bad deal by any standards.

I have several proposals to offer concerning this problem. They are based on maintaining the revenue neutrality of the bill. Through the congressional authorizing committees, instruct OPM

to provide minimum benefit levels for Federal/postal Medicare recipients, for example, nursing home care.

Have FEHBP remain the principal source of payment. At the end of the year, the individual programs would present OPM a bill to cover the additional costs. Money for reimbursement would come as an entitlement from the Treasury. While this solution would create temporary monetary problems for us because the entitlement would not come until the end of the year, the increased coverage will keep people in FEHBP, where they get the most protection.

Or, Congress could increase its copayment to retirees from 60 percent to 75 percent. Currently, active letter carriers receive a 75 percent payment copayment because the USPS adds 15 percent to the government's share. This solution would have an unintended, positive side effect. Many postal employees complain that when they retire they lose the 15 percent USPS share at the same time their take home earnings decrease. This solution would remedy that problem.

Another solution would have a yearly treasury entitlement reimburse the individual insurance carriers for whatever is included in the catastrophic coverage. In conjunction with OPM, the entitlement would be earmarked to the increased health coverage for retirees enrolled in the plans. Since we already negotiate with OPM on costs and coverage, this proposal would not significantly change current practice. However, it would allow the plans to significantly increase other important catastrophic needs, such as eyeglasses, mammograms, and nursing home care.

Any of those solutions would mean that persons eligible for FEHBP, that is, Federal/postal retirees, Members of Congress and their staffs and others would be getting something for the money they're spending. Furthermore, it carries out the spirit of catastrophic health insurance, that is, provides the best possible care for the elderly.

If we don't offer a solution. Retirees are forced to make one of several bad decisions: carry out of Medicare part B entirely, even though they may have paid into it and will lose some benefits under present guidelines and OPM regulations, programs accept coordination of benefit, that is, if Medicare covers it, then we do; pay both Medicare and FEHBP, even though Medicare is of minimal value or opt out of FEHBP, which provides the best coverage for them.

None of those decisions makes good fiscal sense for the retiree or good health sense to a nation beset with staggering health problems.

If the FEHBP plans suffer staggering losses due to enrollees dropping out, the entire nation will pay. As I said before, if we lose a large chunk of our population the premiums become volatile in an upward spiral. Also, since FEHBP programs are offered to both employees and retirees, any change in group plan benefits (for example, eliminating some of the Medicare coverage) to compensate for changes in the Medicare program would penalize others in the group plan who are not Medicare-eligible.

This is compounded by the fact that FEHBP enrollees, shocked by the cost demands of both plans, may drop their FEHBP coverage. They are prohibited by law from reenrolling.

Mr. Chairman, while the problem of double coverage is acute, it is not as dramatic as the inequity in the size of the tax bite which letter carriers would face.

The average retired letter carriers earn $15,000 annuity, which is fully taxed. And therein lies the problem, because it is taxable income, he or she would pay as much as eight times what a social security recipient pays. The figures on our retired carriers are: $580 per year in supplemental premiums for unnecessary coverage.

His next door neighbor, receiving the same pension including Social Security, would pay $210 per year. In other words, Medicare beneficiaries already covered by private catastrophic benefits would be saddled with substantial premium and tax increases but would get no significant increases in protection. That is the unfairness issue in a nutshell.

The simplest solution would be treating the annuities of federal and postal retirees the same as Social Security. There is a precedent: In 1986 Congress rectified the unfairness of Gramm-Rudman by granting our retirement COLA equal status with Social Security COLAs.

Mr. Chairman, $611 per year or $51 month, is not easy for anyone on a fixed, retirement income, particularly when inflation is rising. It is an unfair burden. Once again, thank you for holding these hearings. Many Members of Congress have expressed sympathy with our problem, and are searching for a solution. The only question is how do we reach the solution?

I will be glad to answer any questions you may have.

Mr. ACKERMAN. Thank you very much for your statement.

Don Kaniewski.

STATEMENT OF DONALD J. KANIEWSKI

Mr. KANIEWSKI. Mr. Chairman and members of the committee, I am Donald Kaniewski, assistant to the legislative director of the Laborers International Union of North America, AFL–CIO. As you know, our National Post Office Mail Handlers, Watchmen, Messengers and Group Leaders Division sponsors the largest employee organization plan in the Federal Employees Health Benefits Program. I appreciate the opportunity to appear before you today on behalf of the Mail Handlers benefit plan to discuss the effects of H.R. 2470 and S. 1127, the currently proposed Medicare Catastrophic Protection Acts, on annuitants participating in the Federal Employees Health Benefits [FEHB] Program.

First, I would like to commend you on holding these hearings in such a timely manner. The question before you is of major importance. We all recognize the need for improving the protection afforded older Americans against the devastating effects of catastrophic medical costs. The Congress has embarked on a just cause in seeking to close some of the significant gaps in Medicare protection and the Laborers International Union, including the Mail Handlers Division, wants you to know that we are solidly in support of your objectives. At the same time, we are concerned that

the version of the catastrophic bills finally enacted not impose an unfair financial burden on Federal retirees. We do not believe they should be required, under Medicare, to pay for coverage which they already receive under the Federal Employees Health Benefits Program; nor do we believe they should be required to pay more than their private sector counterparts due to the fact that their Federal pensions are, for the most part, fully taxable. Under the pending catastrophic expansion proposals, Federal, State and military retirees will all find the provisions which would link their Medicare premiums to the unique taxable basis of their annuities to be particularly onerous.

The income-related premium provision would produce an inequity due largely to the difference in tax treatment between Social Security and Federal civil service, State and military retirement income. Social Security benefits are not subject to taxation until all income exceeds a certain level, and one-half of the Social Security benefit is the maximum amount of that benefit subject to tax. Federal annuities, on the other hand, are fully taxable without regard to income levels. According to calculations done by the National Association of Retired Federal Employees, this difference in tax treatment could result in Federal retirees paying a Medicare supplemental premium of as much as four times the premium paid by the Social Security retiree for the same Medicare protection.

Therefore, as a first priority, I would urge this subcommittee to use its influence and good offices to seek a remedy for this unique taxation problem in the Senate version and in conference on the catastrophic bills.

Turning now to the effects of the Medicare proposals on the Federal Employee Health Benefits Program, I would like to first state a couple of rules—I hesitate to call them principles—which I believe ought to deal with the immediate situation of the annuitants and castrophic coverage:

First, we must remember that the fundamental strength of the Federal Employees Health Benefits Program is its competitive foundation.

Above all, this subcommittee should resist anticompetitive proposals such as treatment for selected carriers. When one views this program for historical perspectives, it is interesting to see how the views of certain participants change because of their current situation.

One of the reasons Federal retirees are concentrated in certain plans is that they have been encouraged to remain in them and the plans receive a subsidy provided by Medicare eligibles. This has allowed those plans to price their product at a competitive advantage and retain a share of the market which they would not have kept based on benefits and rates alone.

As the Office of Personnel Management stated in testimony before the Senate on this issue—

> . . . while older people in general are far more expensive to insure than younger people, from an FEHB perspective, since Medicare is the primary payer, retirees with Medicare A and B coverage are relatively good risks. Thus, their presence in plans with expensive populations of non-medicare eligibles helps spread the risk over a broader base.
>
> If the supplemental premium associated with the House bill's provisions leads individuals to withdraw from such plans, this would result in higher premiums for

those remaining. The severity of the premium increase will depend on the particular mix of enrollees in a given plan. We believe the increase for the high options of the two government-wide plans could be very significant and it is possible that their continued viability could be threatened.

In a competitive environment, market forces have a way of delivering justice to the efficient and the inefficient. As OPM also stated ". . . the impact of changes in Medicare and in the behavior of Medicare eligibles will not fall evenly on FEHB plans—some will be strongly affected and others hardly at all." In this instance, I find myself in agreement with the agency.

I would suggest, therefore, that the subcommittee, while weighing this problem and seeking a solution, consider whether we are faced with a program-wide issue or a problem for a very few plans. The administrative difficulties would fall on all FEHB participating plans, but the cost issues may not.

The second rule that might guide the subcommittee is avoid generalizations. When we analyze this problem, we must keep in mind that not all federal annuitants are over 65 years old. In addition, not all annuitants are eligible for both Medicare Parts A and B. So, simply looking at the number or percentage of annuitants within a given plan is a less-than-adequate indicator of the severity of the problem.

We also note that there does not seem to be a correlation between high numbers or percentages and plan price. For example, the GEHA and NALC plans each have more annuitants than does AETNA in its high option, yet both are considerably less expensive. Similarly, Blue Cross Standard Option has almost 45 percent annuitants and a relatively low price, while Alliance high option has 33 percent annuitants and a much higher premium.

Benefit differentials alone cannot account for the difference in pricing. I think all of this goes to show that the available data is contradictory and solutions based on generalizations have a high probability of being flawed.

The Mail Handlers Benefit Plan has about 47,000 annuitant enrollees, about 10 percent, in our high option and about 3,800, or about 21 percent, in our standard option. Like most other plans, we suffer from a lack of data as to which of these are Medicare eligibles. We are hopeful that OPM's effort to match their retirement records with Medicare data from social security will provide a better handle on this or that the agency will authorize the expenditure of funds necessary for each carrier to obtain the type of exact information needed for close analysis.

Rather than focus on the effects of the Medicare catastrophic proposals on the Mail Handlers Plan, we prefer to worry about the inequitable effect on individuals that could result from the unique taxation of Federal annuities or the possibility of mandatory medicare premiums for catastrophic coverage already provided through the Federal Employees Health Benefits Program.

Thus, we strongly recommend that our collective efforts be concentrated in the Senate and in conference toward correcting the problems at their source. We favor pursuing such options as eliminating the taxation inequity, permitting federal retirees to opt out of the unneeded portions of Medicare, and, failing this, a time-window exemption for FEHB participants in order to give this sub-

committee adequate time to design reasonable and practical modifications to the FEHB programs to coordinate with whatever is ultimately enacted for Medicare. Once the Medicare catastrophic plan design is set, possible remedies such as the "maintenance of effort by employers who are providing health care benefits" as proposed by Senator Riegle can be evaluated.

On behalf of the Laborers International Union of North America, AFL–CIO and the National Post Office Mail Handlers, Watchmen, Messengers, and Group Leaders Division, I again thank you for the opportunity to present our views and pledge our wholehearted support in working with you on this issue.

Thank you.

Mr. ACKERMAN. Thank you very much for your statement, Don.

Mr. Conners, let me ask you, if I might, because I don't have to ask Mr. Kaniewski, he mentioned approximately 10 percent or 47,000 of his members were retirees. Do you have an idea of how many members of your association fit into that category?

Mr. CONNERS. Our number is 34 percent. The number of people is around 50,000. We can get the exact number for you.

Mr. ACKERMAN. I wanted an approximation for the question I have been asking some of the representatives of large groups that have appeared here today.

Making the assumption, once again, that the current bill survives the conference relatively as is, and that there is a double premium for the double coverage, what would each of your recommendations be to your members, to take the double coverage, pay two premiums or opt for one or the other? I will direct that question to both of you.

Mr. CONNERS. We would certainly lay out to our member all the information that we could. Given the fact that they may have to pay double for what they don't need, I think they would readily see what they had to do. I would recommend that they not pay that kind of money.

Mr. ACKERMAN. Which way would you think or suggest that they might go? Would they drop out of FEHBP?

Mr. CONNERS. I think we would offer them the alternatives. I am not sure which way they would go, but I think we would offer them all the various alternatives and what the cost would be. Don?

Mr. KANIEWSKI. I would like to associate myself with those remarks as well as those of President Biller. That is, we do support the goals and aims of the catastrophic legislation. When it comes to making the recommendation, I guess we, too, would cross that bridge when we come to it by looking at the costs that are then present and laying out the facts as they are at that time.

I don't know that I would want to venture a recommendation at this point.

Mr. ACKERMAN. I appreciate that. Let me pose this: How would you, either of you, evaluate some of the possible solutions that are being mentioned, some of which have been touched upon here today, such as the feasibility of MediGap under the presumption of the bill passing?

Mr. Conners.

Mr. CONNERS. I am sorry. I didn't catch the question here.

Mr. ACKERMAN. The MediGap. How would you respond to that as a possible solution?

Mr. CONNERS. Sir, our problem with that is we don't know just who would pay for that gap. That is one of the difficulties in the situation.

Mr. ACKERMAN. Let me ask the question that I posed previously as well. Are there too many choices? Again, nobody else is listening. Are 430, 400-plus options a viable number? Do we need that in the interest of choice? Is it overkill? Is it too confusing? Does it provide the greatest amount of latitude or is it inefficient, or should we be dealing with a more limited universe?

Mr. CONNERS. I believe there are entirely too many. I don't know what the minimum should be, but certainly a lot less than what was previously offered.

Mr. KANIEWSKI. With respect to that, Mr. Chairman, it is like prunes, is one enough, one too many? We favor competition in the system and when it comes to individual enrollees, I am advised by Mr. Wells their choices are actually far less when it comes to each individual enrollee.

I wouldn't want to venture that six plans are enough or 400 too many, because of the variety of services provided in each of those plans.

Mr. ACKERMAN. Thank you very much.

Mr. Myers.

Mr. MYERS. Thank you, Mr. Chairman. How many different benefit plans do you have within your own plans in the NALC benefit plans? How many do you have?

Mr. CONNERS. We just have the one.

Mr. ACKERMAN. How about the mail handlers? Do you have more than one?

Mr. KANIEWSKI. We have two options, a high option and a standard option.

Mr. ACKERMAN. The NALC is self-insured; is that accurate?

Mr. CONNERS. That is correct.

Mr. MYERS. Have you set the premiums for 1988 yet?

Mr. CONNERS. Yes.

Mr. MYERS. How much did they go up from 1987 to 1988?

Mr. CONNERS. I think ours went up about 7 or 8 percent.

Mr. MYERS. How about the mail handlers?

Mr. KANIEWSKI. They are up 37 percent.

Mr. MYERS. 37. Why would there be such a marked difference? How did you hold yourself down to 7 or 8 percent, George, or whoever is going to answer the question?

Mr. CONNERS. I was not the one that negotiated, so I can't take the credit for that. But President Sam Bado was the one who handled those negotiations, but I think it had to do with the composition of the plan and all the variable factors that enter into setting the premium.

I don't have an exact answer for you, sir.

Mr. MYERS. We have discussed this morning from your low of 7 or 8 to 31 to 38.5, then 37 percent. If it is all these variables that have been discussed today, the inflation rate, higher cost of medical care, it would seem to be constant throughout all the programs, yet yours is only 7 or 8 percent.

Mr. GOULD. One of the problems we have, Congressman, is the negotiations we go through with OPM. Since 1981, those have been very central and very difficult to project. What we have tried to do is present a plan that will continue to cover our membership in the most comprehensive manner possible, and we can't predict either what the difference is going to be from year to year.

The constant open season and the constant change of strategy on behalf of OPM and the needs of our members makes it impossible to determine what is going to happen or to have any kind of control over what happens.

So, we are disturbed about the process itself. It is not a good way, from our point of view, to deal with health benefit coverage.

Mr. MYERS. I hate to belabor this and will not beyond this point, but we all understand that there has been some inflation, but nothing compared to 30 percent or 38 percent, and I don't know how they justify it.

I am anxious to see the figures that went into that.

Mr. GOULD. It isn't just inflation. Some plans are so comprehensive, so-called Cadillac plans, that try to cover major costs. Other plans have two options, as Don said, in which you have a choice of going for a lower option plan. A lot of young people are going to that kind of coverage, because they don't think they are ever going to get sick or they are not going to get very sick.

When you sit down and negotiate, you try to negotiate what your plan is offering your people and the various plans offer different programs, and there is inflation, medical costs that generally run higher than inflation. There is the kind of coverage you give your people, and there is the demographics of the group you cover.

So, all plans have to negotiate based on what they are doing, and it varies.

Mr. MYERS. Thank you.

Mr. KANIEWSKI. Perhaps Mr. Wells could address that 37-percent increase, Mr. Myers.

Mr. MYERS. OK, briefly if you can.

Mr. WELLS. If I could just address it briefly, the plans that participate in the Federal Employees Health Benefits Program, the fee for service plans, are experience rated, and the components that go into the experience rating are not limited just to inflation.

It also encompasses the utilization, that is the amount of benefits that that particular group actually utilized in the past year, and a projection forward into future years as to the amount of benefits that are also going to be utilized by that group.

The amount of utilization is contingent upon the group itself and the demographic components of that group. If a particular group has a great many ill people in it, and these people are using the benefits, then the rates for that particular group are going to be much higher than another group if that group, for instance, had healthier people in it.

So, it is not just the inflation component that indicates what the rate is going to be. It is the utilization of the amount of benefits for that particular year, in conjunction with the inflation projected forward.

Mr. MYERS. I understand all of that, but here are two groups. Are letter-carriers healthier than mail-carriers? Is that what you are saying? Do they keep the rates down?

Mr. WELLS. We are not saying that, because the makeup of the group is very different. The mail handlers benefit plan is open to all Postal employees and retirees, not just members of the mail handlers' organization. When you take the group as a whole and it was used in 1986 and up until May of 1987 when the OPM required the submission for the rates and benefits negotiations, and then project that forward, it would appear that there would be a difference between the utilization in the mail handlers groups and other groups.

Mr. MYERS. Thank you.

Mr. ACKERMAN. Let me try to get some clarification, because now I have some questions on this of both groups.

Mr. Wells, you say that your plan is open to all federal retirees?

Mr. WELLS. The group is open to all postal and federal employees and retirees.

Mr. ACKERMAN. Is yours as well?

Mr. CONNERS. Yes, sir.

Mr. ACKERMAN. What percentage of your group, your enrollees, Mr. Wells, are actually members of the mail handlers, and what percentage might be other?

Mr. WELLS. The mail handlers benefit plan has approximately 505,000 enrollees. Of those 505,000, 100,000 are postal employees, and of the 100,000 postal employees, I would say approximately 25,000 are mail handlers. I do not have those figures with me. I am speaking off the top of my head, but I can provide them for the record.

Mr. ACKERMAN. They actually administer the plan? Is there one plan or do the people have a choice of plans?

Mr. WELLS. CNA Insurance Co. is the underwriter of the plan. There are two options within the plan, a high option and a standard option.

Mr. ACKERMAN. So, there are two options within the same basic plan for anybody who signs up?

Mr. WELLS. That is correct.

Mr. ACKERMAN. George, you have the same? Being self-insured——

Mr. CONNERS. We are self-insured. We have one plan, one option.

Mr. ACKERMAN. One option.

Mr. GOULD. Less than 5 percent of the people that subscribe to our plan are not letter carriers; 95 percent or so are letter carriers.

Mr. ACKERMAN. How many subscribers are there to your plan?

Mr. GOULD. Approximately 190,000.

Mr. ACKERMAN. 190,000.

Mr. GOULD. Approximately 95 percent are letter carriers or retirees.

Mr. ACKERMAN. We are still struggling with the concept of the great disparity of the increase.

Mr. GOULD. We are a self-assured plan, which mostly carries active and retired letter carriers. We offer the plan to people outside of the craft, but most of the people who belong to our plan are letter carriers or retirees.

Mr. ACKERMAN. That is a remarkable difference in premium increase, 7 percent as opposed to 37 percent. I don't know. That is a 500-percent——

Mr. GOULD. Part of this was explained a moment ago, and that is their universe is different than ours. Because they do have a high proportion of people that belong to their plan that are not mail handlers, they take in people that would have a different impact on the usage of their plan.

Mr. MYERS. Would you yield? Do you all pay the same premium when you are in the craft or not? If I come to the letter carriers, do I pay the same premium?

Mr. GOULD. You pay the same premium. There is an associate membership fee, but once you pay that constant associate membership fee, the premium is the same.

Mr. ACKERMAN. I think we are going off on a tangent here, which is not necessary the focus of this hearing, as interesting as it might be.

Mrs. Morella?

Mrs. MORELLA. As a matter of fact, it is fascinating. You had better be careful because the letter carriers are suddenly going to have everybody that wants to buy into that particular system if they are eligible.

All I can tell you is when I have to participate in any one of these runs that we have around here, I am going to ask that I get a surrogate who is a letter carrier and maybe you had better put in a wellness program for the mail handlers.

I am just curious about the kind of creative suggestion that the letter carriers have in here. I am not sure I understand how they all operate, nor do I believe we need to spend too much time now, since we have other people on it, but there was one on page 5 which indicates that a yearly Treasury entitlement to reimburse the individual insurance carriers for whatever is included in the catastrophic coverage, and then with OPM that entitlement would be earmarked to expand health coverage, which might be eyeglasses, mammograms and then long-term care.

Can you just explain briefly, just give me a little example of how that would work?

Mr. GOULD. Basically, it comes from a concern that with the double coverage, as you thoroughly understand, this suggestion would allow a participate in the Federal Employees Benefit Plan to have other benefits and that the additional benefits would be paid for out of their trust fund.

The alternative would be they would have to pay for that benefit, too, so they would have additional benefit. They would pay for that while they are still paying double coverage for catastrophic.

Mrs. MORELLA. Who establishes the trust fund?

Mr. GOULD. It would be established by Congress. It would be an entitlement like social security or some other entitlement.

Mrs. MORELLA. So, when they pay the double coverage, what they pay into the Federal plan would be held out and put into this trust fund.

Mr. GOULD. That is exactly right. They would be getting something for their money. Otherwise, the money would come out of the plan or out of their pockets, and we don't resolve the problem.

Mrs. MORELLA. You start getting into long-term care. That might end up being a pretty expensive situation.

Mr. GOULD. Catastrophic is already expensive. While we support the concept, we didn't ask for the legislation, and the passage of the legislation now is doubling our cost without increasing the benefit.

Mrs. MORELLA. Thank you, Mr. Chairman.

Mr. ACKERMAN. I think now I understand your measured response as to what you would advise members as far as if the bill prevailed. You have a particular situation where your cost containment seems to be a lot lower than the industry standards' latitude has been permissive of, for whatever reasons.

That might bear looking into to see where you have gone right. The only thing that we have heard here today as opposed to some of the other presentations is the self-insured factor of it, and maybe we can learn a little bit more about whether or not that is an accurate conclusion, not that we are concluding anything, from the next panel, which we are about to hear from.

Let me thank both of your very active and supportive groups for appearing today before the committee and your testimony is very, very important to us as we proceed with our deliberations. We hope, Mr. Conners and Mr. Kaniewski, we will be in touch with you, because your advice is critical to this committee's functioning.

Thank you very much.

The final panel will be Mr. Harry Cain, senior vice president, Federal programs, Blue Cross-Blue Shield; Mr. Charles Bell, vice president, employee benefits division, The Aetna Life Insurance Co.; and Mr. Robert Pfotenhauer, chief executive officer, Group Health Association, speaking for Group Health Association of America.

Thank you for appearing today. Mr. Cain, we will begin with you.

STATEMENTS OF HARRY CAIN, SENIOR VICE PRESIDENT, FEDERAL PROGRAMS, BLUE CROSS-BLUE SHIELD; CHARLES BELL, VICE PRESIDENT, EMPLOYEE BENEFITS DIVISION, THE AETNA LIFE INSURANCE CO.; AND ROBERT PFOTENHAUER, CHIEF EXECUTIVE OFFICER, GROUP HEALTH ASSOCIATION, SPEAKING FOR GROUP HEALTH ASSOCIATION OF AMERICA

Mr. CAIN. Mr. Chairman, I am Harry Cain of the Blue Cross-Blue Shield Association. You have a copy of our text. It is the same text that we presented a short while ago in the Senate, and I would like to apologize, because we are about to change what we said.

Mr. ACKERMAN. Don't apologize. We do that all the time around here.

Mr. CAIN. We have in just the past week developed a proposal we think would solve the problem, and I do want to take the opportunity today to try to present it to you.

Before I get to the new proposal, though, I want to assure you that we do still support what is in our prepared text. In fact, I want to underscore its central conclusion. It is that as a total program, the FEHBP has some serious problems, quite apart from this

catastrophic issue. The catastrophic proposals now in the Congress have served to bring some of the FEHBP problems to the fore.

Our prepared text tries to describe those underlying problems and their causes and some possible changes in the program that would improve the FEHBP. I think you can't read OPM's text presented here today without concluding that the program is flawed and that it has problems that really do require the Congress' attention.

Therefore, even if the immediate catastrophic problem is solved, we urge you to plan a set of comprehensive hearings in 1988 on the total program, out of which could come, we think, some important improvements in the program.

Now to our proposal. I want to say first, we are sorry we were so slow to put a new proposal on the table. The catastrophic proposals are obviously quite far down the track in Congress, and any new proposal would undoubtedly have been appreciated more highly if it had been presented earlier in the process.

I confess that we kept hunting for some possible answer simply because we very strongly support the catastrophic proposals, and we became appalled by their potential impact on Federal retirees, about half of whom are subscribers in our own Blue Cross-Blue Shield plans.

We think that the following change in the catastrophic proposal would handle the present problem. First, a new Part C would be established just for the catastrophic protection. Second, Part C would be optional. Each beneficiary could choose whether or not to join Part C.

Part C, however, would be paid for in essentially the same way as the present House and Senate proposals require. That is, first, there would be a relatively small, flat premium for all Medicare beneficiaries. Second, there would be an income-related premium for all who sign up for Part C.

Now, obviously, when you put that together with real world realities, a large percentage, probably over half, of the current beneficiaries who have higher incomes and/or are already covered by catastrophic protections elsewhere, won't choose to participate in Part C, although at any time in the future, if their circumstances change, they could still participate in such a Part C.

That is the essence of our suggestion. We have described it in some greater detail in a communication we sent yesterday to Senator Pryor. I have a copy here, and I would ask that it become a part of the hearing record.

I think we sent a copy of it to all of you.

Mr. ACKERMAN. Yes. We have a copy of it before us. We appreciate it. It will be made part of the record, as your entire statement will.

Mr. CAIN. I believe, sir, that concludes my summary.

[The statement of Mr. Cain follows:]

TESTIMONY

of the

BLUE CROSS AND BLUE SHIELD ASSOCIATION

on

EFFECT OF MEDICARE CATASTROPHIC PROPOSALS
on the
FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

before the

SUBCOMMITTEE ON COMPENSATION AND
EMPLOYEE BENEFITS

COMMITTEE ON POST OFFICE AND CIVIL SERVICE

U.S. HOUSE OF REPRESENTATIVES

by

Harry P. Cain, II
Senior Vice President
Federal Programs

Wednesday, October 7, 1987

Mr. Chairman, I am Harry Cain, Senior Vice President of the Blue Cross and Blue Shield Association. On behalf of the 78 Blue Cross and Blue Shield Plans that participate in the Federal Employees Health Benefits Program (FEHBP), I want to express our appreciation both for the subcommittee's action in holding this hearing, and for the opportunity to testify.

The Blue Cross and Blue Shield Association has supported the concepts underlying the Medicare catastrophic proposals which both Houses of Congress have been considering. In particular, by extending Medicare to provide catastrophic benefits to all beneficiaries, the proposals assure that many low income elderly who now have neither private Medigap nor Medicaid coverage will be protected. Moreover, a financing structure tied to taxable income will assure that this coverage does not place too heavy a financial burden on the low income beneficiaries. Unfortunately, given the particular benefits and financing mechanisms proposed in H.R. 2470 and in S. 1127, these bills would have some unintended negative effects on federal annuitants who participate in FEHBP and are also Medicare beneficiaries.

The purpose of this testimony is to provide our view of the proposed Medicare catastrophic bills' impact on the FEHBP in general and on the Blue Cross and Blue Shield Government-wide Service Benefit Plan (which we refer to as our Federal Employee Program, or FEP) in particular.

In the last several weeks, we have looked at this problem from many different angles, and have tried to formulate possible solutions that would not adversely affect other aspects of the FEHBP. At this point, we do not

believe that such a solution is available. We believe that, with the exception of an adjustment in the treatment of retirement income, any short term "fix" -- such as refunds, or more benefits, or a Medigap option for annuitants -- is either impractical or will create additional problems for the entire program. Our bottom-line conclusion is that the problem posed by the Medicare catastrophic proposals should be addressed and resolved only in the context of more comprehensive changes in the FEHBP.

The Immediate Problem

Let me briefly review the impact that the catastrophic proposals would have if there are no other changes in the overall FEHBP.

First, the current situation:

Our Subscribers who are federal annuitants and who are also Medicare beneficiaries are already covered for nearly all of the benefits which would be added by S. 1127 or by H.R. 2470, plus important additional benefits. For these beneficiaries, we cover the Medicare deductibles and copayments, we waive our own deductibles and copayments, we provide more mental health and home nursing care, and we cover 100 percent of prescription drugs. In addition, these beneficiaries generally will pay less for medical fees which are in excess of the Medicare payment allowances on unassigned claims. We do not, however, cover skilled nursing home benefits, except for prescription drugs and non-routine durable medical equipment.

The government, in its role as employer or former employer, now pays a large share (from 37 percent to 75 percent) of the premium for those benefits, and the annuitant pays the remainder.

If the catastrophic proposals become law,

1. The cost to the FEHBP for these benefits would drop significantly. We estimate a total annual savings of about $100 million in 1989, assuming the benefits in H.R. 2470, or about $70 million, assuming the benefits in S. 1127.

2. Of the total $100 million savings, approximately $60 million would be a savings to the Office of Personnel Management (OPM), and the other $40 million would result in some reduction in premiums paid by FEHBP subscribers. Such a premium reduction, however, would benefit all subscribers in the affected Plans, not just the Medicare eligible subscribers.

3. The total cost to the Medicare eligible annuitants for health insurance would rise substantially without any compensating increase in benefits. In the aggregate, the additional cost to these annuitants would probably exceed $100 million in 1989, due both to the proposed progressive financing structure and to the fact that retired government workers would pay a higher income-related premium based on taxable income than would other retirees who receive a larger portion of their retirement income from Social Security benefits which are nontaxable.

4. Thus nearly everyone in the FEHBP -- the government, as an employer, and most employees and annuitants -- would benefit from the catastrophic proposals except the people they were designed to assist: the Medicare eligible annuitants.

5. The Medicare eligible annuitants may therefore want to exercise whatever other choices they have. They could:

   a. change FEHBP carriers or options to get the cheapest one available, or
   b. drop out of the FEHBP, or
   c. drop out of Medicare, (Part B).

None of these choices is a satisfactory solution for the Medicare eligible annuitants. Whichever choice they made, they would lose either benefits or money or both.

Short-Run Solutions

What can be done? One approach is to change the treatment of government workers' retirement income, so that their income is no more taxable than it would be if it consisted mostly of Social Security payments. The purpose would be to at least put retired government workers (federal, state and local) on a footing equal to retirees in other sectors of the economy. As a matter of equity, this seems to us an important first step. It would reduce the extra tax burden on the annuitants, though they would still pay twice for the same catastrophic benefits if they remained in the FEHBP. Thus this would be only a partial solution.

A second approach would be to try to return to the Medicare eligible subscribers the actuarial equivalent of the new catastrophic benefits, either in the form of additional benefits or cash refunds. Though these ideas appear reasonable they are not very feasible. Providing enhanced benefits, at this level of actuarial value, would probably provide more benefits than the annuitants want or would like to pay for. Their benefits are already quite comprehensive. (One exception to this conclusion is that a long term care benefit might be designed, as an additional value for these beneficiaries. We are giving serious thought to this idea, possibly extended to all annuitants, and it may be feasible for the long run. For the short run, however, the potential cost and complexity of offering such a benefit nationwide are too great.)

The idea of a refund also has a number of drawbacks: (a) we do not know who all the Medicare eligibles are, at least until they've filed a claim, (b) the mechanics of refunds for one segment of federal subscribers are time consuming and expensive, as we learned two years ago, (c) the refund would have to be an annual event, if the subscribers were to be compensated for their continuing increased Medicare obligations. The only reasonable way to handle that would be in the form of reduced premiums, which would set up another pricing structure for Medicare eligibles. Currently, this is not authorized by the law. In addition, it would, over time, separate these beneficiaries more widely from other annuitants who are not so fortunate as to be eligible for Medicare.

Finally, an idea which has been drawing a lot of attention is to authorize a Medicare Supplemental or "Medigap" option for the Medicare eligible annuitants.

At first glance, this idea has much to commend it. If such an option were available, the Medicare eligible annuitants would then be getting no more than what they (and OPM) paid for. Unfortunately, such an option would also raise the premiums for most other subscribers, would probably cause some current plans to close, and would threaten the stability of the entire FEHBP. How could these things happen?

To fully answer that question would require a review of the entire program and its history, which is hard to do in less than several hours. In the few pages that follow, I will try to summarize the key points in such a review.

First, let me telegraph the conclusions of our review of this subject. There are four:

1. The FEHBP has long been in need of structural reform. Some of the program's features have combined to violate a basic principle of insurance, which is to spread risk as widely as possible.

2. Over the last 20 years, Medicare's payments on behalf of some federal annuitants has been one of the factors that has enabled the FEHBP to cope with the fundamental flaws in the program's structure.

3. In order to solve the problem presented by the catastrophic proposals, the relationship between the FEHBP and Medicare will have to change. A change in that relationship, however, without other changes in the total program, could easily be the thread that unravels the fabric of the overall FEHBP.

4. Therefore, we recommend that the subcommittee plan now to hold comprehensive hearings on the total FEHBP, and be prepared, if the catastrophic proposals become law, to propose a set of programmatic changes which will both handle the problem presented by the catastrophic bills and will get the FEHBP on a more solid foundation.

Now let me provide the basis for those conclusions.

The FEHBP and Adverse Selection

The most widely known and most popular feature of the FEHBP is the annual open season opportunity provided to each employee and annuitant. As you know, each year, each participant has the opportunity to change from one carrier or option to any of a wide variety of other carriers or options. Moreover, the number of choices increases each year as new carriers enter the program. The choices confronting the participants vary both by benefits and by prices. Once these annual choices are made, the government pays its share of the premium to the carriers selected; the government's contribution is the same no matter what the health characteristics or health needs of the employees or annuitants who sign up.

We have been tracking the choice behaviors of people who have joined our program, or who have left it, for many years. The dynamics involved in the choices are very complex, but the bottom line is simple to understand. People either make a change in carrier, or stay with their current carrier, to best suit their own needs. In any one year, people who change carriers tend to be younger, healthier employees or annuitants who are not currently utilizing health care services. They do, however, consider their future needs before making a change. Over a number of years, the impact of these behaviors in the aggregate is to concentrate higher risk people in some plans and lower risk people in other plans. The newer plans, or carriers new to the program, tend to attract the lower risks, the older plans tend to retain the higher risks. That phenomenon is usually referred to as "adverse selection" and "favorable selection." It means that a fundamental principle of insurance, to spread the risks as equally and widely as possible, is violated.

Over the long term, any carrier that tries to offer comprehensive benefits, and attracts and retains more than its share of high utilizers, will have to greatly increase the price of its plan, or the affected option, and the affected subscribers will increasingly choose to go elsewhere. People who will stay in one option or one plan for a long time while the price gets higher and higher tend to be the highest utilizers of health care. When high utilizers of care eventually move to some other option or carrier, the cycle will begin again for their new carrier. It is an inherently unstable system.

Let me give an example from our own program. We have approximately the same number of subscribers in our High Option Single plan as we have in our Standard Option Single plan. The populations enrolled in these two options are roughly the same in terms of age, sex, and annuitant status.

We use the same utilization review procedures, the same hospitals and doctors, and the same cost containment programs in both options. The benefits are more comprehensive in the High Option than in the Standard Option but the hospitalization benefits are not greatly different. The difference in utilization, however, is dramatic. The High Option population has twice (200 percent!) the days of hospitalization per year as the Standard Option population.

I would point out that the FEHBP is not unique in suffering from this problem. Not only are some other employers experimenting with this kind of multiple-carrier, multiple-choice program, but the Medicare program faces the same problem in trying to promote the use of Health Maintenance Organizations (HMOs) which will assume the underwriting risk for Medicare enrollees. For each area for the country, Medicare pays essentially a flat price, adjusted only for demographic factors, for each such enrollee. We now know that such demographic adjustments account for less than 10 percent of the legitimate variation in health care utilization among the Medicare population. Therefore, unless any particular HMO attracts a broad range of people from the Medicare population, who will in the aggregate present an average risk, the HMO stands to either make a sizeable profit or "lose its

shirt" and be forced to withdraw from the program. The Health Care Financing Administration realizes that this is a problem and is currently searching for ways to cope with it.

Over its 25 year history, by accident or intention, the FEHBP has managed to keep this problem somewhat under control or by periodically raising the government's contribution rate, or by relying on other payers, or by benefiting from unexpected shifts in utilization patterns, or by the fact that many employees and annuitants do not exercise their right to change carriers. This is not the time to review that entire history, but a few points should be made.

Perhaps the key factor in FEHBP's survival thus far is that relatively few employees and annuitants change plans each year. If there were as much changing of carriers or options each year as there could be, the problem would be significantly worse than it is. We have explored the reasons why people do not change carriers or options as often as they could, and the answer is fairly straightforward. Choosing a health insurance plan in this environment, especially if one is anticipating the need for care, is a very complex economic decision having potentially far-reaching consequences. It requires a great deal of individual effort to consider the choices available and make the wisest selection, given the many variables to consider. Not surprisingly, in any one year, most people decide not to make the investment of time and energy required to make such a choice. For most people, most of the time, unless there is a major change in benefits or costs, they will stay put. For the age 65 and over population, where health care needs are so great, this is a particularly difficult set of choices to make.

When I spoke of FEHBP's relying on other payers to help cope with the problem, I was referring primarily to Medicare. Because there are no "Medicare supplemental plans" authorized for federal annuitants, the Medicare-eligible annuitants choose any of the regular offerings from the participating carriers. When they do use health care, however, Medicare is the primary payer. As I indicated earlier, for these subscribers we cover all of the Medicare deductibles and copayments and also provide a number of other benefits which are not now provided by Medicare. Nonetheless, the Medicare eligible beneficiaries who are FEP subscribers effectively carry more than their own weight in the program. This is extremely important for all other subscribers, particularly for all of the annuitants who are not eligible for Medicare. In our programs now, we have several hundred thousand annuitants who are either under the age of 65 and thus not eligible for Medicare, or who are age 65 and over but are not eligible for Medicare because their work history did not allow it.

If the Medicare eligible participants in the FEHBP either dropped out of the program entirely, or switched to a Medicare supplemental option if one were available, or dropped their Medicare coverage, the premiums for many other people would rise. The full effect of adverse selection would then be apparent for all to see. The impact, of course, would vary widely from Plan to Plan. In our High Option plan, for example, the rates would rise substantially, whereas in our Standard Option plan, the rates would not be significantly affected. If one looks only at the numbers or the percentages of Medicare eligible annuitants in those two options, one could not guess what the effect of a Medigap option, for example, would be. Our Standard

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Option population has a much higher percentage of Medicare eligibles than High Option, but the impact on High Option would be much greater than in the Standard Option. The overriding issue is selection.

We believe that the committee should be concerned about the adverse selection problem for at least two reasons. First and most importantly, if the problem grows suddenly worse, the affected carriers or options would be in jeopardy, their plans and subscribers could become uninsurable, at least temporarily, and, to say the least, OPM's operations could be severely disrupted.

That sequence of events could occur if some major change in the FEHBP caused a much larger than expected number of subscribers to switch plans during the next open season.

Second, the adverse selection problem, in a competitive environment like FEHBP, can also be described in terms more directly pertinent to this hearing. Annuitants, by and large, are high utilizers of health care. In a competitive environment among carriers, where lower prices are important, annuitants are not usually seen as "desirable" subscribers. They use "too much expensive health care," and thus drive up the premium rates. In the FEHBP, this potential problem has been softened by Medicare. Because many annuitants have Medicare coverage, annuitants as a group are less costly to the FEHBP carriers than they otherwise would be. Without that Medicare coverage, the incentives rise for many carriers to avoid annuitants as far as possible, or at least to work hard, primarily through sophisticated

marketing techniques, to enroll no more than their competitors! While this is not a major factor in the adverse selection dynamic, and many carriers, like ourselves, are committed to assuring easy access and good service for all, the potential for some subtle discrimination against annuitants should not be ignored.

Long-Run Solutions

We believe there are several possible approaches to a reform of the FEHBP. We are not at all confident as to which of the possibilities would make the most sense. Before the Congress should attempt such program reform, however, we would recommend that a number of preliminary questions be addressed in some hearings on this subject. These preliminary questions should include the following:

- What is the total cost of the FEHBP to the government (as employer), and to the subscribers? The assumption underlying the program is that the competition promoted by the FEHBP structure will result in lower prices for the same value of benefits. We are not confident that that is in fact the result.

- What is the current nature of the competition among carriers in the FEHBP? In our view, the competition should be on the bases of value of benefits, quality of service, efficiency of administration, and effectiveness of cost containment. In fact, however, most carriers have learned that the best way to succeed in this market is to enroll healthier subscribers. When the focus of competition is on the

selection of the enrollees, rather than on the value of the product, the program is not serving its own purposes.

- What is the current size, and the likely future cost of the administrative burden on the Office of Personnel Management? Not only do all the new entrants (carriers/plans) to the program exacerbate the adverse selection problem, they also clearly add to OPM's managerial problems. If the Office of Personnel Management were to provide proportionately as much oversight to every one of the now 500 participating carriers as it does to us (and it should), the staff of the OPM would have to be several times larger than its present size.

- Is the government inadvertently leading the private sector astray by allowing the FEHBP in its current form to continue? Unfortunately, in many sectors of the economy the FEHBP is seen as a "model" to be emulated by others in developing health benefit programs. Employee-choice programs are rapidly developing in other places, and to the extent they incorporate the same features as the FEHBP contains, their long-term future is frankly bleak.

- For the 65 and over annuitants who do <u>not</u> have Medicare coverage, should the government extend Medicare to cover them? At what cost? To whom? With what impact on FEHBP and on Medicare?

- Does the private sector have some different ways of offering health coverage, particularly to retirees, that the government (as employer) might want to consider?

If the Congress fully addresses those questions, and concludes, as we have, that the FEHBP must be reformed, there are essentially four alternatives to consider. (Each of these assumes that the government will continue to want private insurers to underwrite the program.)

1. The FEHBP could become a group insurance program in the more traditional sense. For this purpose, the government could divide itself into any number of groups, for example, by department or agency. For each group, a carrier could be selected through competitive procurement for some reasonable multi-year period. Each such carrier could be required to offer a set of choices to the employees in that group, such as HMOs, preferred provider organizations, traditional fee-for-service, etc. As long as there were only one underwriter per group, and the risk could be spread across all options, the adverse selection problem would be solved. Solving the selection problem in this fashion, however, would reduce the range and number of choices available to the subscribers, and would greatly reduce the number of carriers participating in the program.

2. The current structure of the FEHBP could be retained, if the government contribution were altered to compensate for risk selection. That is, employees and annuitants would still be offered a broad range of

choices, including Medigap options. However, the program would use a pricing structure which more accurately reflects the actuarial value of each of the products being offered. Then, at the end of each open season, the government would evaluate the enrollment in each carrier and would adjust its contribution to the various carriers to reflect the varying degrees of risk. If multiple carrier, employee choice programs are to succeed in the long run, we believe this is the only viable way to do it.

Admittedly, this approach is technically difficult. The necessary "risk adjustment" cannot be based only on utilization experience because that would take away a carrier's incentive to be administratively efficient and programmatically effective in cost containment. On the other hand, if the government used only demographic factors for the enrollees, such as age, sex, annuitant status, etc., we know that only five to ten percent of the adverse selection problem will be accounted for. Nonetheless, we believe this is a solvable problem. The solution does not have to be perfect to be a major improvement over the current situation.

3. The current program could be made even more competitive, without addressing the adverse selection problem. The law could be amended to allow more carriers, or at least to allow all current carriers, to offer whatever options they want. Currently, we are restricted to offering only two options, but would like to be able to offer additional options such as an option designed only for annuitants, or a

very low-cost economy option, or possibly a Medicare supplemental option. If we had that flexibility, we believe that we and other carriers could cope with the selection problem. The obvious problems with going in this direction are that it makes the employees' choice problem even more complex, it compounds the administrative problem faced by the OPM, and some subscribers such as annuitants, who are less willing to change plans, will pay higher and higher premiums.

4. Taking the pro-competitive logic to its ultimate end, the government could offer vouchers for every beneficiary. There is a "de-regulatory" attractiveness to this option, but its feasibility is very low. A voucher program absolutely would not work without an almost perfect risk adjuster, and that is currently beyond our technical reach.

The subcommittee has also asked for our comments on two proposed amendments to the Medicare catastrophic bill, S. 1127. Our detailed comments on these proposals are contained in our September 9, 1987 letter to the Chairman, a copy of which is attached for the record. In summary, we are concerned that a FEHBP reenrollment option for federal annuitants may, because of adverse selection, result in higher rates for FEHBP subscribers and the government. In addition, for the reasons cited above, we suggest that the proposed study of Medicare supplement options for federal annuitants be broadened to address other alternatives and a comprehensive review of the structures of the FEHBP.

Conclusion

In conclusion, our recommended approach to this problem is twofold. One, revise the income-related premium under the Medicare catastrophic bill to equalize the burden between retired government employees and others, and two, initiate a comprehensive review of the structure of the FEHBP. We believe that the problem posed by the catastrophic insurance proposals is a serious one needing resolution, but not without full consideration of its ramifications. If the Medicare catastrophic problem is the only problem addressed, we fear that the total FEHBP will suffer as a result.

Mr. Chairman, our testimony today raises more questions than it offers answers. The subject is truly challenging, even to those of us who have been working on it for several years. Nonetheless, we are quite optimistic that the FEHBP, with any of several possible modifications, can be put on a solid foundation for the foreseeable future. By and large, the program has served federal employees and annuitants quite well in the past. We would be pleased to assist this subcommittee in any way we can to ensure that the program continues to serve its subscribers well in the future.

Thank you.

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Blue Cross
and
Blue Shield
Association

Mary Nell Lehnhard
Vice President

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Washington, D.C. 20006
202/783-6222

September 9, 1987

The Honorable David Pryor, Chairman
Subcommittee on Federal Services,
Post Office and Civil Service
Committee on Governmental Affairs
601 Hart Senate Office Building
Washington, DC 20510

Dear Mr. Chairman:

The purpose of this letter is to provide comments on the two amendments concerning federal annuitants that you may offer to the Medicare catastrophic bill, S. 1127. As a health benefits plan that has participated in the Federal Employees Health Benefits Program (FEHBP) since its inception and as the program's largest carrier, we are pleased to provide these comments.

We share your concern about the effects of the Medicare catastrophic bill on federal annuitants who are covered under both Medicare and FEHBP. Most of these individuals and certainly all of those enrolled in the Blue Cross and Blue Shield service benefit plan already have catastrophic insurance through their FEHBP carrier and pay a premium to maintain this coverage. However, if either of the pending Medicare catastrophic bills were enacted, these individuals would be subject to higher Medicare Part B premiums and a new income-related premium, thus resulting in significant increased costs for no gain in insurance protection. Moreover, retired government workers will pay a higher income-related premium based on taxable income than other retirees who receive a portion of their retirement income from Social Security benefits which are nontaxable. We support congressional efforts to help assure that the enactment of a Medicare catastrophic bill does not place an inequitable burden on federal annuitants. We are concerned, however, that the two amendments you are now considering would have unintended negative effects on the stability of the FEHBP.

The first amendment would allow federal annuitants who are currently enrolled in the Medicare program and the FEHBP to drop their FEHBP coverage and reenroll in the program at a later date if the annuitant experiences a reduction in Medicare catastrophic benefits. We believe that this proposal would adversely affect the FEHBP in two ways. First, those annuitants who drop their FEHBP coverage are likely to be reasonably healthy individuals. Less healthy individuals are likely to maintain their FEHBP coverage. This will have the effect of increasing rates in FEHBP since the remaining pool will be in the aggregate, less healthy. Second, once out of the program, those individuals looking to return to the FEHBP are likely to be annuitants

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who are experiencing poor health and believe they need additional health care protection. This future influx of additional less healthy individuals will further weaken the pool and result, again, in an increase in rates for FEHBP subscribers and the federal government.

The second amendment would require the U.S. Office of Personnel Management to conduct a study and report to Congress on the feasibility of providing Medicare supplemental plans as a type of health benefit plan for federal retirees. Allowing FEHBP carriers to offer a new Medicare supplemental policy to retirees with Medicare eligibility would result in higher premiums for others. This is because the Medicare-eligible retirees would drop their existing coverage, which would then become more expensive due to the high costs to the program of retirees who are ineligible for Medicare. We recommend that the amendment not only require OPM to conduct a study of the feasibility of offering Medicare supplemental plans but also identify and analyze other alternatives for providing comprehensive health care coverage to annuitants at a reasonable cost without adversely affecting the FEHBP.

Our recommended approach to this problem is twofold: one, revise the income-related premium under the Medicare catastrophic bill to equalize the burden between retired government employees and others; and two, initiate a comprehensive review of the structure of the FEHBP. While we recognize that this approach is not optimal, we do believe it would avoid disruption in the FEHBP and maintain the basic financing and benefit provisions of the Medicare catastrophic bill.

We are pleased to have the opportunity to provide these comments and would welcome the opportunity to discuss these issues further with you or Mr. Ed Gleiman.

Sincerely,

Mary Nell Lehnhard

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cc: Mr. Bill Lawson
Blue Cross and Blue Shield of Arkansas
Mr. Edward Gleiman

Mr. ACKERMAN. Thank you very much.

We appreciate your statement, and the entire text as stated will be part of the record.

Next will be Mr. Charles Bell, Vice President of the Employee Benefits Division at Aetna.

STATEMENT OF CHARLES BELL

Mr. BELL. Thank you, Mr. Chairman.

We, too, have a written statement which we request be placed in the record.

Mr. ACKERMAN. Without objection, it is made part of the final record.

Mr. BELL. I will summarize that statement in that it focuses on three key issues we feel are relevant here. One is that the proposed expansion of Medicare would unnecessarily duplicate coverage now enjoyed by most elderly, while ignoring the catastrophic risk of long-term care as noted by Congressman Fazio.

Second, regardless of what happens with medicare, the structural limitations of FEHB threaten the plan and create significant excess cost to the Federal Government.

Lastly, if the proposed expansion of Medicare is adopted, modification of FEHB with respect to Medicare-eligible annuitants would become imperative. As you have pointed out, these annuitants already have excellent catastrophic coverage, though at an unnecessarily high price.

The proposed change would force them to pay twice for this coverage. Medicare beneficiaries' perceived need for additional coverage arise from the program's substantial cost-sharing requirements and exclusions, but most beneficiaries, including Federal annuitants, already have coverage that effectively supplements medicare.

Nearly 70 percent of them have privately purchased coverage and another 10 percent qualify for coverage under medicaid. We believe the remaining 20 percent could be reached through far less sweeping measures than H.R. 2470.

We urge Congress to approach this issue more selectively and to concentrate its efforts on working with the private sector to address the real time bomb in the system, long-term care of the chronically ill elderly.

FEHB is a clear example of the duplication which would be caused by medicare expansion. The indemnity plans' catastrophic coverage is already superior to that proposed by either the House or the Senate. The plan essentially assures that Medicare-eligible annuitants can receive virtually 100 percent coverage of most costs recognized by medicare.

In addition, the plan covers most amounts billed in excess of Medicare-allowed charges, as well as prescription drugs and preventive dental care. Thus, proposed legislation would simply shift payment for certain expenses from FEHB to medicare.

Annuitants would gain no additional benefits, but they would pay the increased Medicare premium with no reduction in their required FEHB contribution. This is because there is no flexibility in

FEHB to recognize the redundancy. This is clearly not equitable to the annuitants.

Before addressing potential solutions, however, I would like to point out that this is merely the most visible symptom of a basic structural problem within FEHB. Medicare eligible annuitants heavily subsidize other enrollees. Medicare eligibles have the lowest average claim cost because the indemnity plan is secondary to medicare. Nevertheless, all enrollees are required to pay exactly the same premium, though their actual costs differ substantially.

We project that in 1988 the average claim cost for a Medicare eligible annuitant will be about half that of an annuitant over age 65 who is not eligible for Medicare but who pays exactly the same premium. Each year all enrollees have the opportunity to change plans and select an option that seems to best meet their own needs from the overwhelming array of plans. Over the years, the necessity to increase premiums for all indemnity plan participants in order to subsidize the high cost groups has caused the enrollment profile of the plan to deteriorate markedly.

Younger, healthier individuals have migrated to lower cost plans where the subsidy is not required. Those who are older with established medical problems tend to remain behind, further increasing the average cost. The indemnity plan currently covers about 300,000 enrollees, of whom Medicare annuitants make up the largest single group, about 120,000. There are about 60,000 more annuitants over age 65 who do not have Medicare and another 30,000 annuitants under age 65. Active Federal workers make up the remaining 90,000 participants.

Thus, annuitants make up about 70 percent of indemnity plan enrollees compared to 55 percent in 1981. This is because total enrollment has declined by over 130,000 since 1981, roughly 80 percent of which is due to the loss of younger, healthier, lower cost active employees. We believe that their decision to leave has been heavily influenced by relative changes in the premium cost compared with other plans. This trend has caused a severe financial strain on the indemnity plan and, as importantly, has also created a significant excess cost to the federal government which in a perverse way further aggravates the problem as set forth in our written testimony.

We believe the excess Federal cost due to this adverse selection phenomenon amounts to tens of millions of dollars or more annually. We strongly endorse and look forward to participating in a comprehensive review of the program through OPM.

Turning specifically to the Medicare-eligible annuitants, if Congress decides to enact a catastrophic bill, it will force them to seriously reconsider their participation in FEHB. They will not only be asked to subsidize other indemnity plan enrollees, they will suffer a significant increase in total cost with no net gain in benefits. However, for them to choose to drop out of either FEHB or Medicare, would be a substantial sacrifice in benefits and in either case, would create severe financial problems for FEHB.

We should seek ways to enable annuitants to remain covered by both plans, by making the cost of both more equitable. For Medicare, this means equalizing the income on which the Medicare premium is based. For FEHB, this means allowing carriers more flexi-

bility in setting benefits and rates. This, in turn, would require that the formula for determining the Federal contribution to the plans to be restructured.

Long term, we propose that carriers be permitted to establish separate benefit plan options for Medicare eligible annuitants. A possible interim solution is to establish premium requirements in subgroupings to reflect the true underlying cost of benefits. These groupings could be active employees, annuitants eligible for Medicare and annuitants not eligible for Medicare. Such a change would cause the premium for annuitants eligible for Medicare to decline substantially, however, it would increase the premium for those not eligible for Medicare.

This emphasizes the need for concurrent restructuring of the Federal contribution formula. We believe this can be done in a relatively straightforward way which addresses the immediate need of Federal annuitants. Our written testimony includes examples of the rates which might result under the indemnity high option plan under several alternatives. This may help answer part of the question you raised earlier.

We would be happy to examine other alternatives if it would be helpful. Longer term, we believe that in order to control government costs and to keep the FEHB viable, the employer and employee contribution strategy for all plans must be revised to control adverse selection. Employee contributions should be based on the underlying value of the benefits rather than on the experience of the plans.

We are eager to cooperate with this committee and to assist in the development of viable solutions to this problem. Thank you.

[The statement of Mr. Bell follows:]

STATEMENT OF CHARLES T. BELL, VICE PRESIDENT, EMPLOYEE BENEFITS DIVISION, AETNA LIFE INSURANCE COMPANY

Mr. Chairman, I am Charles Bell, Vice-President, Employee Benefits Division, Aetna Life Insurance Company and a Fellow of the Society of Actuaries. Aetna is one of the leading insurance company providers of individual and group life and health insurance. Since 1960 Aetna has administered the Government-Wide Indemnity Benefit Plan offered by the Federal Employees Health Benefits Program (FEHBP). The Indemnity plan is the fourth largest component of FEHBP.

I am pleased to have this opportunity to discuss proposed Medicare catastrophic legislation and its effect on health benefit plans available to federal annuitants. My remarks center on three issues raised by proposed expansions of Medicare and their effects on federal annuitant's health care coverage. These are:

1. As proposed, Medicare catastrophic legislation would duplicate coverage now held by most Medicare beneficiaries but would do little to relieve their primary catastrophic health care expense - long term care. Therefore, we believe that proposed legislation is inappropriate.

2. Regardless of what Congress decides on Medicare catastrophic legislation, FEHBP's legal constraints, which were reasonable in its early years, no longer serve the plan well. These constraints encourage adverse selection which needlessly increases annual federal outlays for FEHBP and severely threatens the viability of the program. Therefore, a major review and revision of FEHBP is appropriate.

3. If the proposed expansion of Medicare were adopted, modifying FEHBP for Medicare-eligible annuitants would become an urgent imperative. These annuitants already pay an unfairly high price for coverage which includes a substantial catastrophic benefit. Proposed Medicare changes would force them to pay twice for catastrophic coverage with no improvement in benefits.

THE NEED FOR MEDICARE CATASTROPHIC COVERAGE

Medicare beneficiaries' perceived need for supplemental coverage arises from the program's substantial cost-sharing requirements. For inpatient hospital care, Medicare beneficiaries must pay a deductible for each spell of hospitalization and coinsurance for stays exceeding 60 days. In addition, beneficiaries must pay a full per diem for each day in excess of 150 days covered by Medicare. For physician, laboratory, and many other medical services, beneficiaries are responsible for 20 percent of the Medicare approved charge, plus the difference between a provider's actual charges and Medicare's allowed charges. No coverage is provided for outpatient prescription drugs or ancillary coverages, such as dental or vision care.

Most Medicare beneficiaries, however, including federal annuitants, already have health plans that effectively supplement Medicare. Altogether about 80 percent of all Medicare beneficiaries already have expanded coverage through other public or private programs. Nearly 70 percent of Medicare beneficiaries have either individually-purchased

"Medigap" coverage or are covered by an employers' retiree health plan. These plans typically provide coverage consistent with or in excess of that proposed in the Medicare expansion. Another 10 percent of beneficiaries with very low income qualify for the Medicaid program which pays Medicare's cost-sharing amounts and covers many other services excluded by Medicare.

We believe that the remaining minority of beneficiaries currently lacking catastrophic expense coverage could be reached through less sweeping and disruptive measures than those pending before Congress. In this regard, we urge Congress to focus on providing Medicare supplemental coverage to the relatively small group of poor elderly who have no supplemental coverage, by expanding the Medicaid program.

Rather than duplicate acute care catastrophic programs, we would prefer to work with Congress to develop an appropriate private-public approach to managing the real time bomb in the system, long term care of the chronically ill elderly. Nursing home care accounts for 80 percent of catastrophic expenses for those over age 65 who incur out-of-pocket health costs exceeding $2,000 per year.

PROPOSED MEDICARE CATASTROPHIC COVERAGE AND THE INDEMNITY PLAN

The FEHBP clearly demonstrates the duplication and disruption which would be introduced through Medicare catastrophic coverage legislation.

Proposed Medicare catastrophic legislation would limit a beneficiary's liability for most acute medical care costs, at least with respect to Medicare allowable services and charges. Although the House and Senate versions differ in details and approach, in each case they limit the beneficiaries' share of Medicare approved costs to about $1700 per year. The House-passed version would reimburse prescription drug expenses at 80 percent for amounts exceeding $500. Neither bill, however, would pay for amounts billed by providers in excess of the Medicare approved charge, nor would they cover dental, vision or hearing care.

The Indemnity plan's catastrophic coverage is already superior to that proposed by either the House or Senate. For Medicare-eligible annuitants, the plan essentially supplements Medicare to the point where beneficiaries can receive virtually 100% coverage of most medical costs recognized by Medicare. In addition, the plan covers most amounts billed in excess of Medicare allowed charges, as well as prescription drugs and preventive dental care.

For annuitants not enrolled in Medicare, routinely available plan options allow beneficiaries to limit their portion of total expenses for any serious illness to approximately $1700. Once again, this figure includes most provider charges and prescription drugs.

THE EFFECT ON FEDERAL ANNUITANTS OF MEDICARE CATASTROPHIC PROPOSALS

In effect, then, proposed Medicare catastrophic legislation would simply shift payment for certain catastrophic expenses from FEHBP to Medicare. Medicare-eligible annuitants would have no better benefits but their Medicare premium would increase dramatically. As approved by the House of Representatives, the additional Medicare premium could exceed $500 plus another $500 for a Medicare eligible spouse, depending on the annuitants taxable income. There is no flexibility in FEHBP to adjust for the redundancy. This is clearly not attractive or equitable to the annuitant.

In addition to the financial implications, these proposed changes would have the effect of withdrawing a promised benefit from some federal annuitants. Under current and historical FEHBP provisions, retiring federal employees may have concluded that the continued coverage of these benefits on a subsidized basis through FEHBP was an integral part of their employment relationship with the federal government.

EXPERIENCE UNDER THE GOVERNMENT-WIDE INDEMNITY PLAN

Before discussing potential solutions to the burden placed on Medicare-eligible annuitants by the proposed Medicare catastrophic expansions, I would like to point out that it is merely the most

visible symptom of the basic structural problems faced by FEHBP in the current environment.

The Indemnity plan currently covers about 300,000 federal employees and annuitants. Of these, annuitants with Medicare make up the largest single group, currently about 120,000. There are about 60,000 annuitants over age 65 who do not have Medicare and about 30,000 annuitants under age 65. Active federal workers make up the remaining 90,000 Indemnity plan enrollees. (See Table 1)

TABLE 1. ESTIMATED 1987 INDEMNITY PLAN ENROLLMENT

Active Employees	90,000
Annuitants below age 65	30,000
Annuitants over age 65 Not Medicare-Eligible	60,000
Annuitants over age 65 Medicare Eligible	120,000
TOTAL ALL ENROLLEES	300,000

A brief review of financial results for the Indemnity plan demonstrates that Medicare-eligible annuitants are already heavily subsidizing both active enrollees and annuitants who are not Medicare-eligible. Under the statute governing FEHBP, all of these groups are required to pay exactly the same premium even though their actual cost profiles are substantially different. Because the Indemnity plan is secondary to Medicare, Medicare-eligibles are the group with the lowest claims costs. As a result, they provide a substantial subsidy to other enrollees. This subsidy also occurs in all other FEHBP plans.

We project that in 1988 the average claims cost for a Medicare-eligible annuitant will be less than half that of an annuitant who is not eligible for Medicare, even without the proposed change in Medicare benefits. Claims costs for Medicare annuitants will be between 55 and 65 percent of the costs for annuitants under age 65. (See Table 2)

TABLE 2. Average Claims Costs in Dollars and Costs for Annuitants with Medicare As A Percent of Other Groups Costs

	1988 Dollars		Medicare Annuitants Average Claims Costs As A Percent of Average for Other Groups of Enrollees	
	Single	Family	Single	Family
Annuitant with Medicare	$1,100	$2,300	100%	100%
Annuitant over age 65 (without Medicare)	2,400	4,500	46%	51%
Annuitant under age 65	2,000	3,500	55%	66%
Active Employee	1,300	2,600	85%	88%
Average Claims Cost	1,500	2,800	73%	82%

Source: Aetna calculation based on 1986 Indemnity Plan Paid Claims Report

Claims costs are composites of high and standard option enrollees.

THE EFFECTS OF PLAN SELECTION AVAILABLE TO ANNUITANTS

Each year, all enrollees in FEHBP have the opportunity to change plans and select an option that best meets their benefit needs and cost parameters from among the available choices. Over the years, the necessity to increase premiums for all Indemnity plan participants in order to subsidize the high cost annuitants who are not eligible for Medicare has caused the enrollment profile of the plan to deteriorate markedly. Younger, healthier individuals have migrated to other plans where the subsidy is not required. Those who are older, with established medical and service relationships, tend to remain behind. This further escalates the average cost profile of the Indemnity plan.

Today annuitants comprise approximately 70 percent of total enrollment in the Indemnity plan, compared with 55 percent in 1981. Total enrollment in the Indemnity plan now stands at about 300,000, some 30 percent lower than 1981, when there were about 435,000 enrollees in the plan. Roughly 80 percent of the decline in enrollment in the Indemnity plan has been by younger, healthier, lower cost active employees. For the most part, we believe that their decision to leave the plan has been heavily influenced by relative changes in the premium cost compared with other plans.

This trend has caused a severe financial strain on the Indemnity plan and other similar primary FEHBP plans. It has also created a significant and unintended cost burden on the federal government which, in a perverse way, further aggravates the problem.

In actuarial terms, this problem is called adverse selection. In simple terms, it means that, given the option, each individual will choose the plan which provides the lowest cost or best benefits related to their personal circumstances.

The excess government cost arises because the government contribution toward any plan option under FEHBP is controlled by a dollar amount determined from the average cost of six large plans which include a disproportionately large number of annuitants. As younger, healthier employees leave the Indemnity and Service benefit plans for one of the more than 400 other plans that do not have large numbers of annuitants and older active employees, the contribution formula drives up the federal subsidy for all plans. This in turn makes the competing plans look that much more attractive to the healthier employees who tend to be primarily motivated by cost, because the federal contribution covers a larger portion of the premium in these lower cost plans.

We believe the excess federal cost introduced due to this phenomenon of adverse selection amounts to tens of millions of dollars or more annually.

The Office of Personnel Management has initiated a comprehensive study of the program. We strongly support the need for such a study on an urgent basis.

THE NECESSITY OF MODIFYING FEHBP

Returning now to the Medicare-eligible annuitants, enactment of a Medicare catastrophic bill will force them to seriously reconsider their continued participation in FEHBP. They will not only be forced to subsidize those who are not eligible for Medicare, they will suffer a substantial increase in total cost with no net gain in benefits. Their only alternatives, dropping out of either FEHBP or Medicare, would substantially reduce their benefits and would sharply increase federal government costs. Without modifying FEHBP's underlying structure, neither these annuitants nor the federal government is presented with any attractive or equitable options.

We believe that both FEHBP and proposed Medicare legislation should be changed to make it attractive for annuitants to remain in both plans. With respect to FEHBP, an appropriate short term solution would be to allow carriers more flexibility in setting FEHBP benefits and rates and for the federal contribution to the plans to be restructured. Specifically, we propose that carriers be permitted to establish three separate benefit plan options: for Medicare-eligible annuitants, active employees, and annuitants without Medicare. The characteristics, needs, and utilization patterns of these groups are sufficiently different to justify separate treatment. Premium requirements in each of the three groupings should be calculated to reflect the true underlying cost and value of benefits.

Such a change would clearly cause some dislocation in cost among different groups. In particular, the premium for annuitants not eligible for Medicare

would rise. This emphasizes the need for concurrent restructuring of the federal contribution toward premiums.

ILLUSTRATION OF RESTRUCTURED PREMIUMS AND CONTRIBUTIONS

We have developed an example for the Indemnity Plan High Option to illustrate one possible solution. Currently established rates for single coverage in 1988 will result in the following premium and contribution levels:

Government Contribution	$35.77	(37%)
Enrollee Contribution	61.31	(63%)
Total Required Premium	$97.08	100%

The first step in restructuring premiums and contributions would be to calculate the "actuarially appropriate" premium rates for the three recommended rating groups. If the federal contribution continued to be calculated with the current formula, the federal government and individual enrollee contributions would be as follows:

	Medicare-Eligible Annuitants	Non-Medicare Annuitants	Active Enrollees
Government Contribution	$35.77	$35.77	$35.77
Enrollee Contribution	30.63	95.58	59.85
Total Required Premium	$66.40	$131.35	$95.62
(as a percent of current premium)	(68%)	(135%)	(98%)

The substantially higher enrollee contribution that would be required for non-Medicare annuitants clearly emphasizes the need for concurrent restructuring of the federal contribution toward premiums. Non-Medicare annuitants would face a 55 percent increase in their contributions. While it

may be reasonable that the higher-cost groups pay more, equity suggests that rate differentials reflect the relative value of available benefits.

A more equitable alternative would be for the government contribution for each group to be set as a percent of the underlying expected cost for the group. Essentially, the federal government would pay the same percentage of the premium for each group that it now contributes for the combined group in the Indemnity plan, about 37 percent. Thus, in the illustration, the government's contribution could be re-distributed as follows:

	Medicare-Eligible Annuitants	Non-Medicare Annuitants	Active Enrollees
Government Contribution	$24.47	$48.40	$35.23
Enrollee Contribution	41.93	82.95	60.39
Total Required Premium	$66.40	$131.35	$95.62

Medicare-eligible annuitants would pay about 32 percent less than their current premium, while other annuitants would pay about 35 percent more. Active enrollees would pay about 1.5 per less. The total federal expenditure would be unchanged.

A further short term alternative would be for the government to pay the subsidy for non-Medicare annuitants in 1988 in order to avoid disruption to that portion of the plan.

Because of data limitations, we are unable to carry this example through the appropriate long term solution. This would be implementing a restructuring of premiums and contributions, across all plans in the program. Enrollee and government contributions might be set as a percentage of the total premium for

each group, across all plans. In order to correct the underlying problem of adverse selection, enrollee contributions should reflect the relative value of benefits available, not the experience under the particular plan. Under this approach, the government's contribution to a plan with a high concentration of inherently high cost individuals would increase but would be offset by reduced government contributions to plans with a lower cost profile. This proposal would not materially affect total government cost nor the total income to the plan since it is merely a redistribution of funds among groups. It would, however, materially improve equity and long term viability of the plan.

CONCLUSION

While administrative implementation of a short term change to improve equity for Medicare-eligible annuitants would be challenging, we believe it should be seriously considered. We believe it becomes virtually imperative particularly if Medicare proposed changes are implemented.

Solving the long term equity problems highlighted by the possible enactment of Medicare catastrophic coverage will require diligent efforts both by OPM and the carriers that participate in FEHBP. In your efforts to provide equity to Medicare annuitants in response to pending Medicare catastrophic legislation, I hope that you will also consider addressing the fundamental problems in the program's current design. My staff and I are eager to cooperate with and assist this Committee to develop viable solutions.

Mr. ACKERMAN. Thank you very much, Mr. Bell. We appreciate your statement.

Mr. Pfotenhauer?

STATEMENT OF ROBERT PFOTENHAUER

Mr. PFOTENHAUER. With respect to the lateness of the hour, I believe you have copies of my testimony and I would like to have it entered into the record and paraphrase it.

Mr. ACKERMAN. Without objection, your testimony as submitted is part of the record.

Mr. PFOTENHAUER. A number of people testifying here this morning have commented on the basic issue confronting this committee of the inequities that would arise to the Federal retirees. The twist I would like to put on the testimony is to talk specifically about some 2 million Federal retirees who belong to HMO's.

As you indicated, I am here this morning to testify on behalf of the Group Health Association of America, which is the major HMO trade association in the country, representing about 70 percent of the enrollment of HMO's in the country.

I believe Congressman Dicks, my former Congressman from the fair State of Washington——

Mrs. MORELLA. Who is your current Member of Congress?

Mr. PFOTENHAUER. I am pleased to share that Congresswoman Morella is my current Congresswoman, and I am pleased to now be in the fair State of Maryland. I was in Congressman Dicks' district for 18 years, and recently moved to Washington.

The comment Congressman Dicks made was that there is a double-whammy involved with the Part B premium increase, as well as the projected increase in FEHBP for the retiree. For HMO members it is a triple-whammy because they have in essence the benefits that are being discussed in the catastrophic legislation.

For the most part, HMO's offer 365 days of hospitalization. They have caps on the amount of copayment that can be made in a given year. Those that are federally qualified have a prohibition against deductibles for certain health services, so those individuals will receive whopping increases in premiums, but they will receive no change of benefits under this legislation.

In my testimony, I indicated that inequity needs to be addressed. What we would suggest is, according to the OPM study, that HMO's be allowed to offer "medigap" policies to as an option to Federal retirees.

Secondly, we would strongly support removing the penalty that now exists for Federal workers and annuitants who disenroll from FEHB and in some instances, to join an HMO and then not being able to rejoin.

As of this day, there are 157 HMO's that have contracts in the country that we feel provide excellent options for a number of the elderly.

Finally, again in an effort to be brief, I would like to anticipate the Chair's question about the number of choices and perhaps submit to you what will be a minority view here this morning.

HMO's have as a central point the notion of competition. I think that the committee needs to consider what the impact would have

been on price increases facing Federal employees this year had that program not been offering a number of HMO's as options.

Most of the premium increases facing Federal employees and retirees in 1988 in HMO's has gone up 5 to 10 percent, and given the significant increase in the Federal contribution, there will be a price decrease in the out-of-pocket or payroll deduction for a number of those individuals, not a 30- to 40-percent increase.

With all respect to my colleagues at the table, I think the presence of those competitive plans, perhaps one can suggest, has even dampened the 30 to 40-percent increases, that has arisen in the indemnity industry.

I will be happy to take your questions.

[The prepared statement follows:]

STATEMENT OF

ROBERT PFOTENHAUER

CHIEF EXECUTIVE OFFICER

GROUP HEALTH ASSOCIATION

ON BEHALF OF THE

GROUP HEALTH ASSOCIATION OF AMERICA, INC.

Good morning Mr.Chairman and members of the Subcommittee. I'm Robert Pfotenhaur, Chief Executive Officer of Group Health Association (GHA), a health maintenance organization (HMO) of almost 142,000 members serving the Washington metropolitan area since 1937. GHA is a participant in the Federal Employees Health Benefits Program (FEHBP). I'm here today on behalf of the Group Health Association of America (GHAA). GHAA is the national trade association for health maintenance organizations. GHAA represents approximately 75 percent of the enrollment in the more than 700 HMOs nationwide. As of December 31, 1986, nearly 26 million people were enrolled in HMOs.

HMOs provide a comprehensive range of health services in return for a fixed prepaid premium. HMOs are able to provide high quality, cost effective health care because their unique delivery structure allows them to control utilization, particularly in the area of inpatient care. HMOs reported average utilization of 427 inpatient days per 1,000 versus a

national average of 920 days per 1,000 last year excluding Medicare, according to the American Hospital Association.

The FEHBP is important to many HMOs. For the 1988 contract year, 487 HMOs, known as "comprehensive medical plans" will participate in the program. These HMOs cover nearly 2 million people or 17.9 percent of federal workers, annuitants and their dependents. In 1970, there were only 10 HMOs serving less than 4 percent of federal employees. For the 1988 contract year the average premium for HMOs in FEHBP rose an average 5-10 percent.

We have been asked to testify today on the issue of FEHBP and catastrophic protection legislation. The Office of Personnel Management (OPM) estimates the overall number of Medicare-eligible annuitants enrolled in HMOs at 76,000, which is nearly 10 percent of the 800,000 Medicare-eligible annuitants in the FEHBP. There may be an adverse impact of catastrophic legislation on HMOs, both those which participate in FEHB and those which do not. In addition, there are currently some problems in coordinating or integrating FEHB and Medicare which we think you may be able to address.

All HMOs already provide "catastrophic protection" for their enrollees. These benefits are generally equal to or in excess of the

benefits provided in the House and Senate catastrophic bills. Both bills are clearly aimed at limiting out of pocket costs and focus primarily on the hospital inpatient expenditures. Most HMOs provide 365 days of hospitalization, some at no additional charge above the HMO premium; while some may have a copayment. In addition, federally qualified HMOs and many state certified HMOs are restricted in the amount they may charge for a copayment and are prohibited from having deductibles for basic health services. Copayment caps put a lid on out of pocket payments and therefore provide effective catastrophic protection.

The problem for HMOs, assuming enactment of catastrophic legislation, is that most enrollees, including federal employees, will not see an appreciable change in their benefits, but because of the "supplemental premium" based on tax liability, they may pay a good deal more for their health coverage. Although GHAA has raised this issue before, there is a strong Congressional committment to treat all Medicare beneficiaries the same - whether they are enrolled in HMOs or are federal employees or annuitants. We believe that some of the characteristics of an HMO - comprehensive benefits, predictable costs, no claim forms, and often care in one setting, will still serve to draw members.

We support the suggestion that OPM study the feasibility of Medicare supplemental policies and we also support including such benefit packages as an additional option available to federal employees and annuitants. Consumer choice has always been important to our members and to federal employees. We believe it is essential to preserve choice and promote competition in the FEHBP. Resolving the longstanding problem of inadequate coordination between FEHBP and Medicare assures this.

The integration problem between FEHBP and Medicare stems in large part from the lack of authority in the FEHB Act for OPM to contract with carriers for Medicare supplemental policies. As a result, Medicare eligible federal workers and annuitants must pay a full FEHB premium in addition to paying a full Medicare premium. This is unnecessary and unfair. FEHB carriers, including HMOs, should be permitted the option of offering a Medicare supplemental policy. OPM has received complaints that FEHBP plans receive full premiums in addition to Medicare revenues. Although OPM receives a credit based on anticipated Medicare revenues, this is spread across the entire membership. As the Mercer Report of 1982 noted, the integration of FEHB and Medicare results in excess coverage. Allowing carriers to offer a Medicare supplemental policy would provide for improved, cost effective benefits for Medicare eligibles. It would also permit carriers to treat the appropriate federal workers and

annuitants in the same manner they treat Medicare eligibles in the private sector.

We would also support removing the penalty now imposed on federal workers and annuitants who disenroll from FEHBP. Unfortunately, under current law, the annuitant who disenrolls from FEHB to join an HMO is not permitted to re-enroll in the FEHBP. This has been a significant barrier to encouraging Medicare eligible federal employees and annuitants to enroll under a Medicare risk contract. In 1982, under TEFRA, Congress created a new type of Medicare HMO contract which was compatible with the HMO delivery system. Medicare eligibles may enroll with an HMO and receive a benefit package which is generally richer than the Medicare Part A and B benefits. In addition, the premium charged often "buys out" the Medicare deductibles and copayments requirements. As of June, 1987 there were 157 HMOs with Medicare risk contracts serving nearly 1 million people. Because the Medicare risk contracts and FEHB do not "interface," FEHB employees and annuitants who are Medicare eligible are not permitted to try an HMO and take advantage of a health benefits option which may offer both broader benefits and a less costly package. We have had informal talks with OPM and HCFA on this issue and understand OPM is developing a proposed regulation which would suspend, but not terminate FEHB enrollment if the employee or annuitant wanted to become a member of an HMO with a Medicare risk contract.

The growing number of federal workers, annuitants and their dependents enrolled in HMOs attests to the acceptance of managed health care as a health benefits option. At the same time, the number of HMOs currently participating in FEHBP demonstrates the importance of the federal population to the HMO industry. While we support the concept of catastrophic protection which HMOs already provide, it is important not to burden Medicare beneficiaries with paying more for a benefits package which will not change appreciably, to disadvantage alternative health care delivery systems or to affect the viability of the FEHBP. At the same time, the impact of catastrophic protection legislation on FEHB brings up other inconsistencies and problems between Medicare and FEHBP which we have outlined. We appreciate the opportunity to discuss the issue and look forward to working with you to develop solutions.

Mr. ACKERMAN. Is it your intention to keep moving from congressional district to congressional district until you have us all lined up?

Mr. PFOTENHAUER. Since I was almost 20 years in the State of Washington, my wife warned me it will be at least 20 in the State of Maryland.

Mr. ACKERMAN. You said your premium will go up approximately 5 percent on average?

Mr. PFOTENHAUER. HMOs, approximately 5 to 10 percent in the FEHB program.

Mr. ACKERMAN. Can you give us your perspective on why that is, why it is increasing at a much slower rate than some of the others?

Mr. PFOTENHAUER. A number of people commented about the impact of new technology and the aging of the population. The reality is that HMO's live within a fixed budget. It is a different approach to the health care package than the traditional system.

You can look at stats and research studies that have been completed over the last several years, and there are a number of striking differences. Perhaps the most startling is the fact that hospital experience in HMO's is about half what it is in FEHB fee for service. Average approximately 420 days per thousand.

HMO's average approximately 420 days per thousand.

Mr. ACKERMAN. Are you attracting people with fewer health problems or younger people? Is your payout less because of that, for some reason, or are the payouts not as large for hospital visits, so therefore you don't attract people in your plan who might anticipate hospital visits?

Mr. PFOTENHAUER. Critics of the HMO say only healthy people join HMO's. Those of us in the industry feel there is adverse selection in HMO's. The major study that was done and completed by the Rand Corp. compared comparable populations in February, a fee for service setting versus HMO settings.

It is probably the largest study ever undertaken and it was supported with Federal research dollars. The results indicated that in comparable population matched by age and sex as well as health status, that the individual in the HMO setting had 40 percent fewer hospital admissions and 28 percent lower out-of-pocket expenses.

I think that is probably the most definitive study ever done, and it would certainly be a retort to those that suggest HMOs don't have sick people in them.

Mr. ACKERMAN. I appreciate that there is that direct correlation between the degree of escalation and costs and the amount you are paying out. But I think you are missing the premise of my question.

If I were incapacitated in some way and went to a hospital, if I had your plan, would you pay the same amount of coverage for my hospital stay as some other plans whose benefits are increasing 35 percent?

Mr. PFOTENHAUER. In most cases, yes. If the indemnity option you had had a copayment and deductible, if you were a member of my organization, Group Health Association here in Washington, DC, you would have virtually all your hospitalization covered.

Mr. ACKERMAN. How can you provide the same coverage at a cheaper cost? If you are telling me it is not a function of health and it is not a function of subscriber profile, is it a function of administration, or am I missing something?

Mr. PFOTENHAUER. It is tied to the comprehensiveness of the benefits. It is tied to the utilization of management that is inherent in HMOs. We live within a fixed budget.

Mr. ACKERMAN. When you say that, what does that mean, "live within a fixed budget"?

Mr. PFOTENHAUER. We have a limited number of dollars. We get a premium for those individuals. That translates into the delivery system. It is prospective, as opposed to a third-party system. It is fundamentally different.

Mr. ACKERMAN. Mr. Bell, would you have any comments on those same questions?

Mr. BILL. Certainly. All of us have been in the business long enough to know that we can probably develop a study to support any view we would like to take. I would take the position that our experience has been that there is a health status difference that is apparent between those people who stay in an indemnity program and those who move to an HMO.

That doesn't mean HMO's are better or worse. It is difficult to compare the stats. We had an opportunity to do a study of several thousand individuals who changed from a large indemnity plan to an HMO plan effective at the beginning of this year and on an apples-to-apples basis, the people who actually moved to the HMO's plan had 60 percent of the claim costs as those who stayed in the indemnity plan the prior year.

So, I think there is certainly room for argument on that point.

Mr. ACKERMAN. I would ask the same question of Mr. Cain. Perhaps you could add to that and comment on administrative costs. Are your administrative costs out of line, whatever that means, compared to HMO's or compared possibly to those who are self-insured?

Mr. CAIN. Well, it is a very large subject. I would agree with what my colleague here from Aetna just said. We have about 100 HMO's ourselves around the country. I certainly agree that HMO's have some powerful cost containment tools and some administrative controls.

But it is also the case that other kinds of plans, such as our Federal employees program, have such substantial cost containment programs underway. More importantly, based on a examination the characteristics of people who switch from one type of carrier to others, the inescapable conclusion is that all of the cost containment devices in the world are not as effective as enrolling a healthy group.

The healthier the group, the easier it is to hold down your costs. I think when you start to consider that whole set of problems, you come back to the way FEHBP has been established.

You have to wonder if there is not some more efficient way to run the whole program. We are convinced there is, and hence, we hope that you all will examine the whole subject before long.

Mr. ACKERMAN. You mentioned some powerful tools at the disposal of HMO's with regard to cost containment. I think that is

maybe a handle on this whole thing, cost containment. What are those tools and why isn't everybody else using them?

Mr. CAIN. Well, I would say that most carriers in the business today are having to use all the kinds of cost containment devices they can. I would say that the principal advantage that an HMO has—and it was referred to a little while ago—is that the provider community has a strong financial incentive in an HMO to constrain the provision of services as far as that is possible and still assure adequate care.

Again, it is a very large subject. I hope that you will pursue it further once the issue that you have called the hearing on can be handled.

Mr. ACKERMAN. Mr. Bell?

Mr. BELL. I think you will find that virtually all plans available on the market today have similar types of cost containment programs, including those we administer for FEHB. One difference between an indemnity program and HMO program is that, typically, the HMO program will involve passing some of the risk for the intensity of service back to the provider, the hospitals or physicians. They are able to do that by constraining the choice of the individual seeking the service. There may be a limited number of places you can go to receive benefits.

Mr. ACKERMAN. Are you suggesting that a limited number of choices is an economically more efficient way of running a system?

Mr. BELL. It introduces a control factor, certainly, that is important in managing that cost, becauses you introduce the providers of care into deciding how much care they can afford to deliver for the price they are going to be paid, as opposed to a fee for service indemnity program which has less control but more choice for the patients.

Mr. ACKERMAN. Would limiting the number of providers from 400 to 50 to 60 or some other number not accomplish the same thing?

Mr. BELL. The number of 450 you are talking about is various plans, not providers. When I say providers, I am talking about hospitals and doctors.

Mr. ACKERMAN. But wouldn't the suggestion be analogous?

Mr. BELL. No, I don't believe the two concepts are analogous.

Mr. ACKERMAN. Let's address the second one directly. Would limiting the number of plans result in significant cost savings?

Mr. BELL. I believe limiting the number of plans is an appropriate thing to do. I think it would result in significant administrative savings. Without knowing exactly how FEHB would look after it was changed, I could not comment on whether it would reduce the total claim dollars involved or not.

Presumably, you would keep the most efficient plans.

Mr. ACKERMAN. You say limiting it to a certain number would result in savings?

Mr. BELL. I think OPM would realize significant administrative savings there, yes.

Mr. ACKERMAN. Mr. Cain, what is your response to that, if there were only 50 plans instead of 450?

Mr. CAIN. I am not sure it would help a lot, if you still keep quite a few choices. When you talk about there being more than 400, you

are talking about the whole country. But people make choices as individuals in particular localities.

The Washington, DC, area has the highest number of actual choices. It is probably around 20, not over 400. So, it is not clear to me that the 400 is the fundamental problem here.

Mr. ACKERMAN. Would any of you care to comment on the self-insured programs and how they are able to do what they are doing? Is that the same thing as the HMOs?

Mr. PFOTENHAUER. Not really, to the extent that HMOs cover a number of groups.

Mr. ACKERMAN. For cost containment?

Mr. PFOTENHAUER. There may be aspects that would have similar features to HMOs in terms of utilization and management.

Mr. BELL. I don't think there is anything inherently superior in a self-insured program. They all have to be administered by an agency and the agencies have all the same tools available. Self-insured programs have lower administrative costs because of certain tax costs they get out from under.

The same tools, though, are there. I think it could be deceiving to look at a 1-year percentage change in price as a true measure of real value. It certainly can be an indicator, but you need to take into consideration the context of where did you start from. Not only that, but what kind of changes have taken place in the composition of your group from time to time and what is the necessity to play catch up, if any, over a prior year's cost.

I think you will find that several of the plans in FEHB this year are well behind and have to play some catch up. You also have to consider the benefits offered and what are the benefit changes that may take place from one year to the next.

Mr. ACKERMAN. Let me, for edification, suggest that one of the reasons I have been harping, if that is the right word, is basically jurisdictional. We have been trying to get a handle, having not had original jurisdiction, in this subcommittee, of what is getting done in the Ways and Means Committee, but other issues such as this come within the purview of this subcommittee.

That is the reason I have taken the time to ask those questions of each of you.

Mr. Myers?

Mr. MYERS. I understand the 400-plus or minus that are available, that you make up most of those plans. You have all those plans within your own organization, do you not? Where do they come from then?

Mr. PFOTENHAUER. A significant number of them are HMOs that I believe are defined for the FEHB program as comprehensive medical programs. But in essence, they are HMO's, yes.

Mr. MYERS. You have most of the 400 in your health organization plans?

Ms. ROSE. I am Leslie Rose of GHAA. There are currently 487 comprehensive medical plans, or HMO's in the program.

Mr. MYERS. You were hitting right at home there, Mr. Chairman.

Mr. BELL. We have two options.

Mr. MYERS. High and low.

Mr. ACKERMAN. This is a meeting where we have had triple-whammies and Hobson's Choices.

Mr. MYERS. I don't understand any of them. I don't understand insurance either, to be honest with you. If you only have two plans, if someone carries Aetna or Blue Cross—how many do you carry?

Mr. CAIN. Two.

Mr. ACKERMAN. We only have two choices to make, either high or low option in your plans. Aren't there choices we have about how much we cover?

Mr. BELL. No, sir.

Mr. MYERS. Then out of the 400-plus, you are only four of them sitting at the table, plus the ones with the HMOs.

Mr. BELL. There are a number of other plans, some of whom you have heard from today.

Mr. ACKERMAN. Will the gentleman yield?

Mr. MYERS. Certainly.

Mr. ACKERMAN. Mr. Cain, you stated before that Blue Cross-Blue Shield has 100 HMO's. Now, despite the fact that you have those HMO's within your organization, what I think you are telling us is that Federal employees, in subscribing to your coverage under FEBP, do not have those choices except for the one plan that you have high option and low option.

Mr. CAIN. We have over 100 HMO's around the country. Half of them are participating in the federal employees health program. Each has a separate contract with OPM. That is quite apart from our high option and standard option Blue Cross-Blue Shield plan available to Federal employees and retirees.

Mr. MYERS. Then you have more than two plans.

Mr. CAIN. Yes, if you include our HMOs.

Mr. MYERS. See why I am confused? Well, as a Federal employee, do we have the same available programs to us that you afford other people throughout the country? Do we have the same choices or do you distinguish between various groups?

Mr. CAIN. It is not exactly the same. But it is essentially the same. We have separate kinds of contracts with all the principal employers that have chosen Blue Cross-Blue Shield. It is really up to an employer or an account or, here, OPM and the Congress, as to what we offer.

Mr. BELL. I think it is fair to say that OPM, as a buyer here, has the same opportunity to work out a plan of benefits with us as any other buyer would have the opportunity to do. Once we have agreed upon that plan of benefits, we deliver it in the same way.

Mr. MYERS. Do the Federal employee plans have a different premium than somebody working for some other company throughout the country?

Mr. BELL. Yes.

Mr. MYERS. I never realized that. I better go and see what I can get back home, shouldn't I? Maybe we are getting the wrong program here.

Mr. BELL. Most plans are what we call experience rated, which means that the premium charged for that group will reflect both the benefits offered to that group and the underlying experience of the people who enroll in that program. So that price is tracked to the actual cost.

Mr. MYERS. Since we are on that subject, what are the premiums for Aetna going to go up next year?

Mr. Bell. I am embarrassed to say, sir, they will go up about 50 percent.

Mr. Myers. How about Blue Cross and Blue Shield?

Mr. Cain. It is about 38 percent.

Mr. Pfotenhauer. Congressman, I would add as opposed to indemnity insurance with experienced rates, most HMOs, certainly those which are federally qualified, utilize a principle of community rating. So to answer your question of whether or not you would have the same premium if you were working for a private company in the Midwest as opposed, as a federal employee, you would basically have the same benefits and the same perhaps minor modifications in benefits, but basically the same rate for comparable benefits if you were covered by another private group as you would by a federal plan.

Mr. Bell. If I may expand for a moment, some of the factors that I noted earlier, both in my presentation and in response to an earlier question, are things that begin to drive these kinds of rate changes. Just the question you asked about shouldn't I look around at some of my local choices to see if I can get something cheaper is exactly what is available to each individual in the FEHB program, whereas in the national programs, such as the ones Blue Shield and the Aetna maintain, we are constrained to use a single price throughout the country for all types of individuals. What realistically happens is those that can get something at a lower rate more often than not will do so unless they have a real reason, such as a health problem, for sticking where they are.

This has caused over the last several years a significant increase in the underlying cost of our benefit program, which I refer to as adverse selection, and which I believe you have heard from OPM as well. That is a factor that has driven those costs much more rapidly than those of many of our competitor plans. It is one of the structural problems in the system that we feel is absolutely in need of addressing on a priority basis.

Mr. Myers. Today Federal employees, the Federal Government matches 50-50, don't they, for premiums?

Mr. Bell. I believe the formula is 60 percent of the average cost of six large plans. This begins to drive what the Federal contribution towards those plans is.

Mr. Myers. Federal Government puts 60 percent and the individual insured puts 40 of the premium? Is that it?

Mr. Bell. That is true for the average over those six large plans. The underlying cost in those six large plans is unduly influenced by high cost utilizers and results in a higher average cost than for those that are not in those plans. So the Government contribution of 60 percent in dollars and cents represents a higher percentage for lower cost plans. It is a vicious cycle type of arrangement.

Mr. Myers. Is Group Health part of the big six?

Mr. Pfotenhauer. I would like to think it might be some day, sir, but no, in no way is it one of the big six. The total HMO enrollment in these 487 plans I believe is roughly 2 million?

Ms. Rose. Let me just add that there are two HMOs however that are part of the big six, and that is Kaiser, Northern California and Kaiser, Southern California.

Mr. MYERS. Does the Government pay 60 percent of the premium for your health organization group?

Mr. PFOTENHAUER. I don't have the exact percentage. I would have to calculate that.

Mr. MYERS. Would you provide it for the record?

Mr. PFOTENHAUER. Certainly.

[The information follows:]

FEDERAL CONTRIBUTION TO GROUP HEALTH ASSOCIATION INFORMATION REQUESTED DURING HEARING

[Percent]

GHA	1987	1988
High self	65	75
High family	54	65
Standard self	75	75
Standard family	69	75

Mr. MYERS. I assume somebody has it. I have taken enough time, Mr. Chairman. Thank you very much. I am thoroughly confused so I might as well stay that way.

Mr. ACKERMAN. If I could just follow up on one question before going to Mrs. Morella, Mr. Bell, I was a little concerned and want to know if you are. You stated that your premium would be going up 50 percent on average, and should the bill be successful as is, people would be paying for double coverage and then Federal retirees additionally paying 8 percent of their adjusted gross income, wouldn't you think a lot of people are going to be taking a look at that? That is a pretty heavy hit.

Mr. BELL. Absolutely.

Mr. ACKERMAN. What do you project that is going to do to your subscribers? You must have made some projections based on this.

Mr. BELL. Included in the 50-percent change was an adjustment for an assumed reduction in the number of lower cost subscribers. This carries forward the kind of experience we have seen in recent years, where we are retaining the higher cost utilizers. If Medicare catastrophic were to pass and a large number of people were to choose either to drop out of FEHB or to drop out of Medicare, either one, it would have a potentially disastrous effect on our financial experience.

Mr. MYERS. I am not sure about this average high six. Mrs. Morella has Aetna.

Mrs. MORELLA. She did have.

Mr. MYERS. I have Blue Cross. Do we both pay you the same premium regardless? The high six has really confused me here.

Mr. BELL. Each plan has a separate premium when it finally reaches you.

Mr. MYERS. We pay a different premium, each one of us, depending on which company we have.

Mr. BELL. That is right.

Mr. CAIN. Yes.

Mr. MYERS. OK.

Mr. BELL. That premium is a combination of the underlying cost and the benefits that you are getting for that.

Mr. MYERS. Run that high six past me again, what that means.

Mr. BELL. The procedure OPM uses to determine how much the Federal Government subsidy is, is an averaging process where they take the premium rate for six large plans, including the Blue Cross/Blue Shield plans, Aetna plans, couple of HMO plans and several others, and figure what the average price there is. They then take 60 percent of that and that becomes the baseline dollars and cents contribution that the Federal Government makes to every plan.

Mr. ACKERMAN. When you say they take the average price, if I may, that is the average payout price or the average premium or——

Mr. BELL. Average premium.

Mr. ACKERMAN. So it behooves the companies to raise the premiums to get a higher matching percentage from the Government.

Mr. BELL. I don't believe so, no.

Mr. MYERS. It would be part of the blend, though.

Mr. PFOTENHAUER. For example, this year our rates for GHA here locally, the standard option is going up approximately 5 percent, the high option about 8.9 percent. There will actually be a decrease in the payroll deduction of our currently some 65,000 Federal employees who belong to us because of the increased contribution on the part of the Government. It will be a 17- to 20-percent decrease in their actual payroll deduction.

Mr. ACKERMAN. That 60 percent being figured on the bigger six benefits the smaller companies because the Government is paying out 60 percent of say your 50 percent increase in premium and that money divided out over subscribers, with you having an increase of 5 percent for your standard as you called it and 8. something percent for your high option, that 60-percent increase is then going to further subsidize and lower the premium paid by your subscribers while your subscriber is going to go up.

Mr. BELL. That is right. It is a competitive disadvantage for us to have a higher rate in that process, because it results in a disproportionate government subsidy for lower cost plans. I would refer back to what I said in my testimony, that longer term that results in a significantly higher total cost for the Government.

Mr. ACKERMAN. What you are saying is possibly the forces of the marketplace, should this trend continue, will obviate the necessity of me asking that question in a couple of years, are there too many choices.

Mr. BELL. Some of the big plans are significantly disadvantaged by that process and yes, they may become nonviable.

Mr. ACKERMAN. Thank you.

Mrs. Morella.

Mrs. MORELLA. It is like Humpty Dumpty said through the looking glass, I am so full of ideas. There is so much that has been talked about but I do want you to know, I have Blue Cross/Blue Shield. My husband has a family plan with Aetna. We may go to the HMO's. When I hear about these premium increases, 50 percent, 38 percent—at any rate, I wanted to comment on the bill that we are addressing, particularly your new proposal for the Plan C.

I wanted to get the benefit of Mr. Bell's comment on it and Mr. Pfotenhauer's response to that Plan C. It does mean Plan B currently is optional; therefore, it would mean that if people are interested in this new optional concept of Plan C, they would have to subscribe to Plan B, too, right?

Mr. CAIN. Our current proposal says yes, that is right, but wouldn't have to be set up that way.

Mrs. MORELLA. In my office I have the statistics. I don't remember them offhand about what percentage do not have Plan B at the present moment.

Mr. CAIN. It is 2 percent only. Almost everyone has it.

Mrs. MORELLA. Only 2 percent. If I might get your comments on that proposal.

Mr. BELL. I, as most here, have just heard about this proposal this morning. We have not had a chance to thoroughly analyze it. I must admit to you my first reaction is rather skeptical. I believe as my colleague has indicated in his testimony, his initial assumption is that over half of the people who are eligible for the program would not enroll in it. That means that those who would enroll in it are those who need it the most. I think there could be a significant cost impact to that kind of selection that would make it very difficult to price and very difficult to predict in that kind of an environment where everybody has the free choice of whether they will enroll or take some other plan.

I think further it runs the rather overt risk of creating direct competition in selling that kind of benefit between something the government is selling under medicare Part C and something private industry is selling through medigap types of policies, and I am not sure that would be an appropriate end product. I would reserve final judgment until we have had a chance to fully analyze the proposal.

Mrs. MORELLA. Thank you. I would like to get your judgment as you have a chance to analyze it. I guess it is a valid consideration certainly that you might not have enough people operating into it to make it physically appropriate. I guess that is another reason why the OPM study is going to be imperative to our deliberations.

Would you also like to comment?

Mr. PFOTENHAUER. We saw the proposal also this morning. We will follow up with some suggestion after we have had a chance to review it. I think Mr. Bell's comments would echo my initial concern of potential adverse selection, depending upon how many people voluntarily would potentially join Part C.

Mrs. MORELLA. You did a good job of using your testimony also to get at the system in terms of changes you felt should take place which I found to be very interesting. Maybe it is something that we also want to consider if not immediately with this bill, certainly following that.

Did you want to comment on that, Mr. Cain?

Mr. CAIN. Just two comments.

First I again apologize for having surprised my colleagues with this proposal. It would require some careful review. The issues just raised as potential problems we tried to take into account, and so I think that the proposal will withstand that kind of scrutiny.

Mrs. MORELLA. It may be that you will want to or be asked to supply that kind of data to confirm that it won't be a major liability.

Mr. Bell, I was also interested in the plans that you offered too within your testimony with regard to the medicare eligible and non-Medicare annuitants and the active enrollees.

Now, your non-Medicare annuitants, how many of them are there?

Mr. BELL. We have 90,000 non-Medicare annuitants, of whom 60,000 roughly are over 65 and 30,000 are under 65.

Mrs. MORELLA. Did you say you have 120,000 who are medicare eligible annuitants?

Mr. BELL. Yes, we estimate 120,000 who are Medicare eligible.

Mrs. MORELLA. It is a very interesting kind of formula that you have here in terms of having active enrollees pay less and you would have your non-Medicare—would that be non-Medicare annuitants that would pay about 35 percent more?

Mr. BELL. Yes. That is indicative of the type of subsidy in the program today. A question asked earlier was is that a fair subsidy and I guess the tone of our remarks would say we don't really believe it is. Even under the proposal that we have suggested there, you could have a net cost reduction to medicare eligible annuitants of over 30 percent today, just by recognizing the underlying cost of the two groups.

But you would have to raise the price for those that you are subsidizing by 30 percent.

Mrs. MORELLA. Who might be in the position where they are least able to pay. I don't know since there are 60,000 of them over 65. Fine.

Mr. BELL. However, their cost is going to continue to go up disproportionately in any event as their plan becomes smaller and smaller and dedicated almost exclusively to their own needs as we see more and more active employees leaving that plan.

Mrs. MORELLA. I think one of the things we have also learned today is that the more you know, the more you know that you need to know. I think you reflected the complexity and intricacy of the problem and the need for us to try to address it with the help of experts. Thank you for participating.

Thank you very much, Mr. Chairman.

Mr. ACKERMAN. Mr. Myers.

Mr. MYERS. I have one question. Often we are asked a question about every time federal employees, retirees or active employees receive a COLA, their insurance premiums go up. As I understand it, regardless of whether there is a COLA paid this fall or not, the premiums are going to go up. COLA has nothing to do with it; is that right?

Mr. BELL. That is right.

Mr. MYERS. People think you watch that COLA and you have another $10, you are going to get 9 of it or 11 of it.

Mr. BELL. Absolutely not.

Mr. MYERS. Thank you.

Mr. ACKERMAN. We thank you for your tolerance, especially of our questions this morning. This group has provided us with a three credit remedial course which we are all grateful for.

Mr. Cain, I wish you particular luck in selling your proposal that some of us have not had the opportunity to look at in any great depth, as I am already told that the staff of the Ways and Means Committee has a response to your proposal.

Mr. CAIN. It isn't surprising that people who have devoted themselves for the last year to developing something, wouldn't be very enthusiastic about a sudden change. That is very understandable.

Mr. ACKERMAN. We at least wanted to make sure you had your say before this subcommittee. We appreciate it. We appreciate the testimony of each of the members of this panel this morning. It has been most edifying and enlightening and we will continue to be in touch with you and your organization as we proceed on this very important policy matter.

Thank you very much for joining us today. The committee stands adjourned.

[Whereupon, at 1:15 p.m., the subcommittee was adjourned.]

[The following statements were received for the record:]

THE HONORABLE STAN PARRIS

TESTIMONY SUBMITTED TO THE HOUSE POST OFFICE AND CIVIL SERVICE SUBCOMMITTEE ON COMPENSATION AND EMPLOYEE BENEFITS

CATASTROPHIC HEALTH LEGISLATION

October 7, 1987

Mr. Chairman, the idea of protecting elderly Americans from the financial burden of a catastrophic illness is a good one. The cost of medical care continues to escalate while the incomes of our nation's elderly remain stagnant or even decline in real terms - the result is an elderly population that lives in fear of becoming seriously ill simply because they cannot afford to deal with the medical expenses associated with such illness.

The approaches to providing catastrophic health care for our nation's elderly recently adopted by the House of Representatives and the Senate, however, are seriously flawed and should not be enacted into law as currently drafted.

Both the House and Senate legislative proposals duplicate catastrophic health benefits presently provided to Federal,

military, and state employees, and many participants in employer-sponsored group health insurance plans. The measures are indiscriminate and would require persons to accept the additional coverage offered whether they want it or not and whether they would benefit from it or not.

Additionally, and perhaps most unfairly, the cost of this duplicative coverage would be charged to our nation's elderly based not upon need or risk but upon income. And, because the income tax surcharge ("premium") for this coverage would be based upon Adjusted Gross Income, the coverage would be disproportionately financed by Federal annuitants who are charged with artificially high Adjusted Gross Incomes due to an inequity in the United States Tax Code that makes Federal retiree annuities fully taxable.

Not only do the House and Senate bills burden a significant number of our nation's elderly with duplicative, expensive coverage, but the proposed legislation fails to address the most immediate need of the elderly - long term health care. Regardless of the good intentions behind the catastrophic health care measures adopted by the House and the Senate, the true effect of the legislation upon a significant number of the measures' intended beneficiaries is anything but meritorious. Rather than continue with my own rhetoric as to why the proposed legislation, as currently drafted, should not be enacted into law, I will quote from letters received from several of my constituents who argue

very effectively that the catastrophic legislation would make bad law and why.

- "As the widow of a civil service employee, I am covered under Blue Cross catastrophic insurance. I am not eligible for Medicare Part A...but I do receive Part B...Can you not see how unfair it would be to me and others if this additional insurance were financed by basing the premiums on taxable income or by tacking the premium onto the Medicare Part B payment only? I personally will never benefit from the Medicare catastrophic hospital coverage...You would almost be forcing me to give up my Medicare Part B coverage if you make it too expensive."

- "I am a retired Civil Servant, age 64 and will be eligible for a small Social Security annuity by virtue of military and industrial service...our income will be such that we will be paying the maximum supplemental premium. I have been enrolled in the government FEHB plan since 1965 and I had planned to continue it after age 65 as my Medicare supplement. Right now our premiums are $30.00 per month...Now, with the Supplement for catastrophic coverage which we do not need, our monthly premiums will increase by $122 per month or a total increase in medical costs of 490%. Do you see what I mean by high cost for middle income?"

- "Since Social Security income is not counted in computing adjusted gross income, and my public pension is fully taxable, I will automatically pay more for the same protection. For example,

a $600 per month social security survivor benefit would incur no supplemental premium while the very same $600 per month civil service survivor's annuity would incur a $90 supplemental premium. This does not seem fair to me...I have catastrophic protection coverage under the FEHB...if I drop the coverage I now have, I can never again enroll in the FEHB program. Unless this situation is changed, I will be trapped into paying higher premiums than others for catastrophic protection benefits I already have."

- "As a federal retiree I have sufficient coverage by Blue Cross/Blue Shield...why should I be penalized by a supplemental premium I do not want?"

- "This is a reduction of income for us of $1200-$2000 per year, a tremendous impact on retirement income, especially since we already have catastrophic protection..."

- "I have Blue Cross/Blue Shield supplemental and have $2 million in catastrophic coverage. It also pays where Medicare leaves off. I strongly object to having to pay $580 a year for coverage I am already paying for...for us whose retirement is fully taxable it is a burden we cannot afford."

For all the above reasons the catastrophic health care legislation, as presently drafted, should not become law.

STATEMENT BY

KENNETH T. BLAYLOCK
NATIONAL PRESIDENT
AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES
(AFL-CIO)

On behalf of the American Federation of Government Employees and the 700,000 government employees we represent, I am pleased to submit this statement on proposed legislation to provide catastrophic insurance protection for the elderly.

The current proposals for catastrophic insurance protection for the elderly seek to address escalating out-of-pocket health care expenses by the elderly in this country. From 1977 to 1984 such expenses have increased by 138 percent, reaching $30.2 billion. There is a clear need for new legislation if the Federal Government is to fulfill its health care responsibility to America's elderly as established in 1965 with passage of the Medicare program.

Of course, the lack of adequate health care insurance is not limited to the elderly. There are over 35 million American citizens who have no health insurance at all. AFGE hopes this country will soon join the rest of the advanced Western industrialized democracies and adopt a comprehensive National Health Insurance program.

We do not seek in this testimony to address the difficult issues of the structure and adequacy of the benefits in the proposed legislation. However, we do want to address two particular applications of the legislation which directly harm federal retirees.

First, both the House-passed bill (H.R.2470), introduced by Fortney Stark (D-CA), and the pending Senate legislation (S.1127), introduced by Lloyd Bentsen (D-TX), seek to base the new supplemental premium on an individual's tax liability

(adjusted gross income) in order to fund the proposed new benefits. This creates a large disparity between retirees with the same income, because of the different tax treatment of that income. In particular, federal retirees, millions of state and local retirees, and retired Congressional employees who are not covered by Social Security would have all of their retirement income taxed while other retirees whose retirement income is based on Social Security would be advantaged by the favorable tax treatment of Social Security. Social Security is not taxed unless the retiree's adjustment gross income, plus one-half of his or her Social Security, exceeds $25,000 ($32,000 for a married couple). Even in this case, at a maximum, only one-half the Social Security benefit would be taxed.

The extent of this disparity is shown in table one and table two which compares the supplemental premium for federal employees with no Social Security income and other retirees with a $6,000 Social Security benefit. ($6,000 is roughly the average Social Security benefit.)

As you can see from Table I, under the Senate proposal the supplemental premium for federal employees would range from $61 at $5,000 of Adjusted Gross Income (AGI) to $378 at $25,000 AGI with effective tax rates ranging from 1.2 percent to 1.5 percent.

This compares to other retirees (with a $6,000 Social Security benefit) who would not begin paying a premium until their income (AGI & SS) exceeded $7,000 and at $25,000 would pay only $244. His or her effective tax rate would range from 0 to 1.0 percent.

With an AGI of $8,000, federal retirees would pay a supplemental premium over four times the amount paid by other retirees! At $25,000 AGI, federal retirees would still be paying half again as much as other retirees.

The House proposal is even worse for most government employees. As shown in Table II, federal retirees would pay an annual supplemental premium of $10 at $6,000 AGI, ranging to $580 at $15,000 AGI and above. This translates into a tax rate of 0.2 percent at $6,000 to a high of 4.0 percent at $14,000. The other retirees (with a $6,000 Social Security benefit) would not begin paying until his/her income (AGI plus Social Security) hit $12,000 and would not reach the maximum supplemental premium of $580 until $21,000. There is a massive $420 disparity in premiums between individuals with equal amounts of income in the $13,000 to $14,000 range.

Recognizing this disparity and correcting it are two separate problems. Ideally, one would take an employee's work history in non-covered employement, calculate what this person would have received from Social Security if such employment was covered by Social Security, and exempt that amount of income. Alternatively, one could include Social Security payments as part of the base for calculation of the supplemental premium for all participants and adjust the rates and base accordingly. This would, we suspect, be politically impossible. If both these approaches are ruled out, we are left with second best solutions.

We can identify three separate approaches for federal retirees, all of them with some drawbacks. (Most of these could be adopted to the other relevant populations such as state and local employees.) One approach would be to define an adjustment factor which could be applied to the calculation of the supplemental premium for individuals whose income is "primarily" derived from federal retirement programs. The adjustment factor could be defined as one minus the ratio of the average Social Security amount divided by the average Civil Service Retirement amount.

The merits of this approach is that it would be relatively easy to calculate and the same exclusion factor could be applied to all individuals who meet the definition. The drawback is that this proposal would be slightly regressive because high income individuals would receive the same proportional adjustment as low income employees whereas they would not have received proportionately as great a Social Security benefit because of the tilt in Social Security benefit structure to low income workers.

In addition, employees who had signigicant non-federal retirement and non-Social Security income (and still met the definition) would be advantaged because the adjustment ratio would apply to that income as well.

On the other hand, employees who did not meet the definition but drew federal retirement would not have any adjustment at all.

Another approach would be to lower the definition of tax liability by any amount equal to the average Social Security

amount times .15 or .28 (which ever is the appropriate rate for the individual according to the tax schedule) for retirees deriving their income primarily from federal retirement programs.

This approach has the drawback of being more difficult to calculate and would be more confusing.

For federal retirees as a whole who in general have a history of higher than average earning, both of these approaches might result in an overall undercompensation as compared to the ideal since both adjustments are based on the average Social Security amount.

Finally, one could leave the definition of the appropriate adjustment to an executive agency, requiring that agency to meet the goal of horizontal equity. The drawback to this approach is that OPM, the relevant executive agency, is, in general, not trusted by government employees.

We urge the Committee to examine these and any other options which the Committee may be able to conceive. Even if a perfect or ideal solution is not achievable for each individual affected, it is important to achieve a basic adjustment which accommodates equitable treatment for CSRS retirees and other affected groups as a whole.

In addition to our concern for equity in funding, the duplication of benefits provides a special problem for CSRS retirees. In the current situation, CSRS retirees can continue their health insurance under the Federal Employee Health Benefit Program when they retire. The benefits in the catastrophic bills under consideration would basically duplicate benefits

already existing in FEHB plans. However, once a retiree drops coverage, he or she is not allowed to re-enroll.

FEHB plans are offered to both employees and retirees, so any change in group plan benefits to compensate for the proposed changes would penalize others in the plan who are not Medicare eligible. Continuing their current FEHB plan and paying even an adjusted supplemental premium would be prohibitively expensive. Yet, retirees would be reluctant to drop their FEHB plan because of the re-enrollment ban.

The Congress could address this concern by revoking the re-enrollment ban outright or making re-enrollment contingent upon changes in the Medicare program. Congress should also consider requiring the two government-wide plans to offer a medigap plan for retirees. Care would need to be exercised so that neither of these options would upset the premium structure in the remaining FEHB plans. If this proves to be impossible, as some have suggested, it may be necessary to review the entire FEHB structure.

AFGE strongly urges this Committee to ensure that these two concerns are addressed as the House goes to conference on this important piece of legislation.

Thank you.

Table I

SENATE BILL COMPARISON (1988)
(Individuals)

* 1 * Adjusted Gross Income (AGI) or Adjusted Gross Income Plus Social Security (SS) (a)	* 2 * Supplemental Premium (SP) for Federal Retiree (b)	* 3 * SP as % of AGI for CSRS Retiree (2÷1)	* 4 * SP for Other Retirees With $6,000 SS Benefit	* 5 * SP as % of AGI and SS (4÷1)	* 6 * Difference in SP (2-4)	* 7 * Federal Retiree SP as % of Other SP (2÷4)
$ 5,000	$ 61	1.2%	$ 0	0	$ 61	--%
$ 6,000	$ 73	1.2%	$ 0	0	$ 73	--%
$ 7,000	$ 86	1.2%	$ 0	0	$ 86	--%
$ 8,000	$ 98	1.2%	$ 24	.3%	$ 74	437%
$ 9,000	$110	1.2%	$ 37	.4%	$ 73	297%
$10,000	$122	1.2%	$ 49	.5%	$ 73	249%
$11,000	$135	1.2%	$ 61	.5%	$ 74	221%
$12,000	$147	1.2%	$ 73	.6%	$ 74	201%
$13,000	$159	1.2%	$ 86	.6%	$ 73	185%
$14,000	$171	1.2%	$ 98	.7%	$ 73	174%
$15,000	$184	1.2%	$110	.7%	$ 74	167%
$20,000	$266	1.3%	$171	.8%	$ 95	156%
$25,000	$378	1.5%	$244	1.0%	$134	155%

a) Since CSRS and other retirees would use the same standard deduction ($3750) and personal exemption ($1,950), it is simpler to use AGI or AGI plus SS to estimate impact

b) Calculated as 12 x $1.02 x (AGI x tax rate of .15 or .28)/150

Table II

HOUSE BILL COMPARISON (1988)*
(Individuals)

* 1 * Adjusted Gross Income (AGI) or Adjusted Gross Income Plus Social Security (SS)	* 2 * Supplemental Premium (SP) for Federal Retiree	* 3 * SP as % of AGI for CSRS Retiree (2÷1)	* 4 * SP for Other Retirees With $6,000 SS Benefit	* 5 * SP as % of AGI and SS (4÷1)	* 6 * Difference in SP (2-4)	* 7 * Federal Retiree SP as & of Other SP (2÷4)
$ 5,000	$ 0	0.0%	$ 0	0.0%	$ 0	--
$ 6,000	$ 10	.2%	$ 0	0.0%	$ 10	--
$ 7,000	$ 70	1.0%	$ 0	0.0%	$ 70	--
$ 8,000	$140	1.8%	$ 0	0.0%	$140	--
$ 9,000	$210	2.3%	$ 0	0.0%	$210	--
$10,000	$280	2.8%	$ 0	0.0%	$280	--
$11,000	$350	3.2%	$ 0	0.0%	$350	--
$12,000	$420	3.5%	$ 10	.1%	$410	4200%
$13,000	$490	3.8%	$ 70	.5%	$420	700%
$14,000	$560	4.0%	$140	1.0%	$420	400%
$15,000	$580	3.9%	$210	1.4%	$370	276%
$20,000	$580	2.9%	$560	2.8%	$ 20	104%
$25,000	$580	2.3%	$580	2.3%	$ 0	100%

* Based on July 17 Democratic Study Group Fact Sheet on H.R.2470

American Psychiatric Association

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STATEMENT

OF THE

AMERICAN PSYCHIATRIC ASSOCIATION

on

EFFECT OF MEDICARE CATASTROPHIC PROPOSALS
on the
FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

before the

HOUSE COMMITTEE ON POST OFFICE AND CIVIL SERVICE
SUBCOMMITTEE ON COMPENSATION AND BENEFITS

by

John McGrath, M.D., Chairman
Joint Commission of Government Relations

Wednesday, October 7, 1987

Washington, D.C.

Mr. Chairman, Members of the Subcommittee, I am John McGrath, M.D., a physician in the private practice of psychiatry in Washington, D.C., and the Chairman of the Joint Commission on Government Relations of the American Psychiatric Association, a national medical specialty society representing over 34,000 psychiatrists. We appreciate the opportunity of sharing with you our views on the proposed Medicare catastrophic bills' impact on the Federal annuitants who participate in FEHBP and are also Medicare beneficiaries with particular reference to the mental health benefit.

First, we want to applaud the leadership you have taken and the deep concern expressed by the Members of the Subcommittee regarding available health insurance, (and the costs associated with that coverage), to Federal employees in the event they fall victim to a catastrophic illness, especially if the illness is due to a mental or addictive disorder. We look forward to the opportunity to work towards a reasoned and responsible means of assuring that Federal employees receive all medically necessary care at a cost that does not add further burden to those already targeted as the scapegoat of the Federal government.

To date, over 100,000 Federal workers, their dependents and annuitants have been directly affected by reductions in their FEHBP coverage for the treatment of mental illness. Despite the historic evidence that we have presented previously and the constantly accumulating evidence that the cost of covering mental and nervous illness was stable and predictable and had held at roughly 7.7 percent of all health benefits paid -- mental health benefits under FEHBP have been significantly reduced. A number of the plans have, since OPM's initial directive in 1980 and without regard to the later indicia of maintaining

the mental health benefit, permitted coverage for such illness in the Federal Employees Health Benefits Program to reach a point that is now much less than that provided in the private sector.

A study conducted by the General Accounting Office in December 1986, entitled, "Comparison of Coverage for Federal and Private Sector Employees," states:

> FEHBP plans have generally curtailed the mental health benefit since 1980, in areas such as the number of days of hospitalization covered, the total benefits paid, and the level of deductibles and coinsurance the enrollee must pay. In 1980, most FEHBP plans (15 of the 18 largest) paid 100 percent of initial mental health expenses for a specified time or to a specified dollar limit. But in 1982, mental health coverage was substantially curtailed. Plans reduced their mental health benefits by (1) covering fewer days of hospitalization, (2) limiting the covered treatment costs, (3) limiting the number of outpatient treatments, (4) raising deductibles, or (5) lowering coinsurance rates. In 1984, OPM asked the plans to restructure the benefit to improve long-term inpatient coverage by adding catastrophic protection. In doing so, the plans further reduced coverage for outpatient care and short-term hospitalizations. Also, in 1984, 12 plans limited their lifetime inpatient mental health coverage to a specified maximum, typically ranging from $50,000 to $75,000. Before this change only four plans had lifetime maximums.

An APA study of FEHBP indicated, in fact, that most of the plans cut mental health benefits by more than 25 percent between 1980 and 1984, with many of the larger plans cutting benefits by 50 percent or more. By contrast, the cuts in the benefits for physical health care were only six or seven percent of the total package. To further illustrate these inequities, in our study we compared the out-of-pocket costs for an employee incurring either $10,000 or

$100,000 in inpatient physical health care expenses in a year to those incurred for inpatient mental health care, under current coverage. In all plans, physical illness is fully protected once a limit (usually $2500) is reached. However, the enrollee incurring $10,000 in mental health costs has to spend $8000 out-of-pocket, and if the expenses are $100,000, the out-of-pocket cost can be as high as $75,000. It is not difficult to imagine the plight of an employee or annuitant who is suddenly faced with this type of expense. Please note, health care discrimination of this sort, against the mentally ill, is not restricted to the FEHBP.

Under the current Medicare program outpatient benefits are restricted to $250 annually after coinsurance and deductibles. Inpatient care in a psychiatric hospital is limited to 190 days per a beneficiary's lifetime. Neither of these provisions have been changed since the inception of the Medicare program in 1965. These discriminatory benefits have a devastating impact on Medicare beneficiaries who need mental health services. For these reasons, both Medicare beneficiaries and those Federal employees and annuitants with FEHBP insurance are greatly at risk of having large out-of-pocket expenses if they or a family member suffers from serious mental illness.

Legislation reforming Medicare to provide catastrophic health insurance is a first step on the legislative journey toward non-discrimination and economic protection for the elderly and chronically mentally ill.

As you know, the House passed catastrophic health insurance bill, contains an expansion of the outpatient mental health benefit. It increases Medicare's coverage of the outpatient psychiatric benefit from $500 (with 50 percent

copayment) to $2000 (with 50 percent copayment). In addition, the coverage for outpatient prescription drugs and care in a psychiatric unit of a general hospital for those with mental and addictive disorders would be treated as it is for patients with a physical illness. Thus, such inpatient treatment would be provided in a nondiscriminatory fashion. At the same time S. 1170, while unclear vis a vis the outpatient coverage, is the same in regard to inpatient coverage.

If catastrophic health insurance legislation were to become law, the effect on Federal employees would be startling. The combination of a 31 percent average premium increase, an anticipated cost increase for Medicare coverage related to catastrophic coverage, and the discriminatory tax treatment afforded Federal employees when computing the cost per person of the Senate bill's Medicare part B premium, would force the annuitant to either incur a tremendous financial burden or rely solely on Medicare coverage for the purpose of health insurance.

Catastrophic coverage appears to provide no added benefit to the Federal annuitant for twice the price except, as stated earlier, with respect to coverage for mental and addictive disorders, because coverage in the FEHBP for treatment of mental and addictive disorders has fallen to levels which can only be described as archaic. These proposed changes to Medicare provide many Federal annuitants access to coverage that few plans were willing to provide in the FEHBP. Of all the FEHBP plans only one, Blue Cross/Blue Shield high option, provides significant outpatient benefits, (50 visits with 30% copayment in 1987). Mental health catastrophic inpatient coverage now has a trigger ranging from $5000 to $8000 per plan, coupled with their lifetime limits of $50,000 to

$75,000. The need of the annuitant requiring acute care for chronic disabling diseases, such as schizophrenia or severe depression, who is totally reliant on the FEHBP for mental health coverage should not, and can not, be overlooked when discussing the issue of double coverage of catastrophic health care for Federal employees.

Perhaps the only constructive thing to result from this dilemma is that attention is being directed to the FEHBP and its impact on the welfare of the Federal employee. When Congress enacted the Social Security Amendments of 1983, the Federal employees became a contributor to the Social Security Trust Fund for the first time. Congress was faced with a dilemma. Should the government require a full social Security contribution and a full contribution to the Civil Service Retirement System from its employees, or should some reasonable combination of the two systems be implemented thereby establishing an affordable retirement system providing a substantial return on one's investment? Certainly, at no time would Members of Congress, or employees of the Federal government have settled for an outcome which required payment to both CSRS and Social Security yet only offered a return on one or the other upon retirement. Perhaps it is time to re-evaluate the FEHBP in an effort to coordinate Medicare and FEHBP coverage.

In the event Catastrophic Health Insurance proposals become law, we propose that an offset plan be explored. As the Blue Cross and Blue Shield Association testified before the Senate Subcommittee on Federal Services, Post Office and Civil Service on the effect of Medicare catastrophic proposals on the Federal Employees Health Benefits Program: "The FEHBP has long been in need of structural reform. Some of the program's features have combined to violate a

basic principle of insurance, which is to spread risk as widely as possible." It could be possible for FEHBP carriers to restructure their benefit packages so that catastrophic coverage for annuitants, but not for active employees, is reduced. Such restructing and its concomitant savings would provide carriers the resources to fund active employees' health care coverage where it is currently lacking or insufficient. Minimum levels of coverage could be mandated in order to protect the plan members from drastic reduction in coverage by the FEHBP carrier or by Medicare.

Such a idea can not be considered anything less than a major undertaking that would require a great deal of time and energy. Still at issue is what to do in the interim for those who retire and are forced to make what is in essence, the decision of a lifetime. Whatever the outcome of the debate, whatever interim plan is implemented, of primary importance is the information provided the employee for making his or her decision. When application for retirement is made, employees should be given access to detailed information explaining how their current coverage interacts with Medicare coverage. Only then can the employee reach a conclusion as to which coverage best meets his or her needs. It would be our hope that particular attention would be focused upon the differentials in coverage for mental and addictive disorders and the tragic discrimination that is permitted to exist, contrary to the best interest of the Federal worker and their families in both human and economic terms.

The Federal employee has over the last few years suffered great injustices. Cost of living adjustments have been given only to be taken away, meager pay increases do nothing to alleviate the discrepancies in wages between the Federal and private sectors, and health care benefits erode in value at a speed equal to their rise in costs. Perhaps this latest attack on the Government's workforce can be rewritten into a legislative victory for the federal employee.

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October 16, 1987

Honorable Gary L. Ackerman — BY HAND
United States Representative
Chairman, Subcommittee on Compensation
and Employee Benefits of the House
Committee on Post Office and Civil
Service
511 House Office Building, Annex I
Washington, D.C. 20515

Re: Hearing on Medicare Catastrophic Protection Act Held on October 7, 1987

Dear Chairman Ackerman:

The Association of Federal Health Organizations ("AFHO") appreciates this opportunity to express its views on the Medicare catastrophic illness protection legislation, HR 2470 and S 1127, which the Congress now is considering. AFHO is a nonprofit association of organizations which are carriers of Federal Employees Health Benefit ("FEHB") plans. AFHO's membership currently consists of 13 employee organization carriers of FEHB plans and a national association representing approximately 140 health maintenance organizations providing health care to federal employees and annuitants. In combination, AFHO's constituent organizations provide FEHB coverage to more than 3,000,000 federal employees and annuitants and their families, accounting for approximately 25 percent of all persons covered by FEHB plans.

Simply put, the enactment of HR 2470 and S 1127 as presently drafted would be a catastrophe for federal annuitants who are enrolled in FEHB plans. That legislation would compel those annuitants to accept and pay for catastrophic illness protection which they already have under

their FEHB plans. See General Accounting Office Briefing Report to Senate Subcommittee on Civil Service, Post Office and General Services, Comparison of Health Insurance Coverage for Federal and Private Sector Employees, p. 35 (Dec. 1986) ("Since 1982 all FEHBP enrollees have had catastrophic protection.") Furthermore, federal annuitants would have to pay more than their private sector counterparts for such Medicare coverage because the Medicare catastrophic illness premium is tied to taxable income, and federal annuities, unlike Social Security payments, are fully taxed after employee contributions to the program have been exhausted in benefit payments.

Moreover, the problem would not be solved, but rather exacerbated, if federal annuitants withdraw from FEHB plans in favor of Medicare catastrophic illness protection. From the annuitants' perspective, FEHB plans serve as "Medigap" policies because the combination of FEHB and Medicare coverage generally leaves the annuitant with no out-of-pocket expense for Medicare covered expenses. In addition, if federal annuitants withdraw from FEHB plans, they would not only lose that protection, but also would be placed at risk for 100 percent of the charges for services such as dental care, prescription drugs, and routine physical examinations which Medicare does not cover, but FEHB plans generally do. See generally General Accounting Office Briefing Report to Chairman, House Select Committee on Aging, Comparison of Medicare Catastrophic Health Insurance Proposals, pp. 32-33 (June 1987).*/ All AFHO member FEHB plans provide federal annuitants with coverage of dental care and prescription drugs. Furthermore, according to the above-referenced GAO report (p. 13), FEHB plans are two times more likely than private sector plans to cover routine physicals. Finally, several FEHB plans offer vision and/or hearing care which under Medicare are noncovered services. In sum, Congress clearly should not compel federal annuitants to abandon their FEHB plan coverage by enacting the pending Medicare legislation.

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*/ The Medicare prescription drug benefit found in HR 2470 has a $500.00 deductible and an 80% copayment. FEHB prescription drug benefits generally have no separate deductible and/or only a very modest copayment -- especially those plans offering mail order maintenance-type prescription drugs which most often are used by annuitants.

From a FEHB program perspective, the loss of federal annuitants to Medicare may threaten the financial viability of certain FEHB plans, including the government-wide service and indemnity plans. The causes of such have been spelled out amply in the statements of other witnesses before your Subcommittee. Therefore, we will not duplicate their efforts here. The crucial point to keep in mind here is that Congress already has provided federal annuitants with adequate (and far superior to the proposed Medicare) catastrophic illness protection through the FEHB program. Congress, therefore, should exempt federal annuitants from the unnecessary, inadequate, and costly Medicare catastrophic illness coverage now being proposed.

In closing, AFHO urges the Subcommittee to reject the opportunistic efforts of certain parties who are attempting to employ this easily correctible flaw in HR 2470 and S 1127 as a basis for overhauling the FEHB program to their liking. During the last five years, the FEHB program has been buffeted too much by such unique occurrences as severe, OPM-mandated benefit cuts and one-time premium reductions or rebates to drastically reduce reserve levels for political purposes. In AFHO's view, the FEHB program now is back on a steady course; thus, because the FEHB program is not broken, it needs no major fixing as some have falsely suggested.

AFHO appreciates this opportunity to express its views on this important matter.

Respectfully,

Thomas J. Feeney, Jr. (JHS)

Thomas J. Feeney, Jr.

cc: Board of Directors
James R. Barnett, Esq.

Statement for the Record by
The Federal Managers Association
on
the impact of proposed health legislation
on the
Federal Employees Health Benefit Program,
before the
Subcommittee on Compensation and Employee Benefits,
House Post Office and Civil Service Committee

The Federal Managers Association would like to thank the subcommittee for inviting us to offer a statement for the record on the effects of the Catastrophic Healthcare Protection Bill on the Federal Employees Health Benefit Program. We appreciate the Committee's interest in seeking to alter the inequities for public sector employees in the catastrophic plan.

There are two problems with the catastrophic care bill. First, civil service annuitants will pay more than those who are covered by social security at identical income levels for identical insurance. Unfortunately for Federal employees, the supplemental premium to pay for catastrophic coverage is based on the tax code. Most social security is not taxable while civil service annuities are fully taxable. Second, not only are Federal employees paying more for coverage, they are paying more for items already covered under the Federal Employee Health Benefit Program. Federal employees already have catastrophic coverage under FEHBP.

In addition to the hardship placed on our retirees by this proposed legislation, these two inequities could cause serious detriment to the FEHBP program itself. Civil service retirees who leave FEHBP cannot come back into the program. They may choose that option instead of paying for double coverage. There is no telling what will happen to the overall cost of the FEHBP for both the employee and the government if this bill becomes law.

FMA supports the concept of catastrophic healthcare protection but coverage should benefit all in the plan, on an equitable basis. In the bill's present form, FMA would be unable to offer its support for this legislation. The old saying of "you only get what you pay for" applies. We wish that were true. However, Federal employees are paying more and getting less.

In closing, we are asking Congress to modify the premium formula so that public sector annuitants do not pay more than other annuitants in the same income category for the same benefits. We feel Congress should coordinate the FEHBP program with Medicare's expanded catastrophic benefits so the benefits are not duplicated and not paid twice by public sector retirees. The easiest answer to this dilemma, of course, is to pass a bill similar to Rep. Vento's (D-MN) bill, H.R. 1938. This bill would treat public sector retirees in the same manner as private sector retirees for purposes of taxation.

There is no easy solution to the problem created by this new catastrophic protection legislation. But we will do everything we can to help you find a solution.

Thank you for giving us the opportunity to submit testimony before the Subcommittee.

STATEMENT OF RAYMOND E. ROWLAND, PRESIDENT
GOVERNMENT EMPLOYEES HOSPITAL ASSOCIATION
TO THE HOUSE COMMITTEE ON POST OFFICE AND CIVIL SERVICE
SUBCOMMITTEE ON COMPENSATION AND EMPLOYEE BENEFITS

THE MEDICARE CATASTROPHIC PROTECTION ACT
(H.R. 2470 and S.1127)

Mr. Chairman, the Government Employees Hospital Association (GEHA) is pleased to be able to respond to your request for comments on legislative proposals embodied in the Medicare Catastrophic Protection Act (H.R. 2470 and S.1127). Our comments will be limited, as you suggested, to how we believe the bills would affect Federal annuitants participating in the FEHB program.

The Government Employees Hospital Association is a non-profit association of Federal employees devoted solely to providing comprehensive health insurance to Federal employees and annuitants. Through its health benefit plan it provides protection to over 300,000 Federal employees and annuitants and their families under the provisions of the Federal Employees Health Benefits (FEHB) program. Including the families of Federal employees and annuitants, we provide health benefits coverage to approximately one million persons. We are a fee-for-service plan and reimburse our members for their medical care expenses in accordance with the coverage provisions of the Plan. While our coverage is comprehensive, our premium cost to Federal employees and annuitants is among the lowest of any plan in the FEHB program.

As we understand the proposed legislation, it would limit out-of-pocket spending for certain Medicare covered services. Also, additional benefits would be added (prescription drugs after a $500 deductible with 20% coinsurance and respite care services for a specified period of time) and certain Medicare benefits now provided would be improved.

Generally speaking, however, the effect of these Medicare benefit additions and improvements on Federal annuitants enrolled in GEHA would be minimal in terms of providing better coverage to them. Overall, there would appear to be only marginal benefit to Federal annuitants from the provisions of the Medicare Catastrophic Protection Act. The additional benefits provided by that proposed Act would not provide greater health benefit coverage to Federal annuitants than they already have under GEHA. Given the additional premium involved, it is clear that Federal annuitants would not get their money's worth.

For example, while H.R. 2470 would propose to limit out of pocket expenses to $2123 plus 20% of the cost of drugs over $500. GEHA protects its members from all out-of-pocket expenses over $2000 per <u>family</u> per year. Should a member incur such expenses on his or her behalf or on behalf of family members (all expenses would be combined), all covered expenses above that amount for the calendar year would be paid at 100% by GEHA, including hospital expenses, physicians services, prescription drugs, medicines, x-rays and laboratory fees. The GEHA deductible is $200 (considerably less than that proposed by H.R. 2470 with respect to drugs alone) and the plan provides private duty

nursing care, home health care, hospice benefits, as well as 100% of hospital room and board expenses without limitation, 80% of other hospital expenses, and 85% for all medical services outside a hospital or as a hospital out-patient. There is no lifetime maximum in the amount of benefits that can be paid except that benefits for mental and nervous conditions and substance abuse are limited to $50,000 per person. Mental and nervous coverage is also limited to 50% of covered hospital expenses after a separate $500 deductible is met.

In view of the broad coverage already provided to Federal annuitants by GEHA, and likely by other plans in the FEHB program, it appears to us that these annuitants would not receive significant additional coverage as a result of H.R. 2470 but would in fact simply pay an additional premium for coverage they by and large now have.

It is difficult to anticipate the effect of higher Medicare premiums and increased coverage by Medicare on Federal annuitant participation in the FEHB program. However, inclusion in the Medicare provisions if non-optional could encourage annuitants to withdraw from the FEHB program. The likely effect of this would be higher FEHB premiums. While older persons are generally higher risk, their coverage by Medicare as the primary insurer lessens the impact they have on the rate structure of the particular plan in which they are enrolled. If they left the plan in substantial numbers, the rates might well need to be increased for all enrollees.

One particular problem we see is the financing provisions of H.R. 2470. Because premiums under the bill would be related to taxable income, the impact would be greater on Federal annuitants without Social Security coverage than upon Social Security recipients. Thus, while the bill would propose to duplicate coverage Federal annuitants already have, it would at the same time require that they pay more for that coverage than their private sector counterparts who are the very persons to benefit from the bill's provision.

The bill does not provide an option to Federal annuitants to purchase the coverage or not. We think it should and they should be able to purchase additional coverage without being required to relinguish coverage under Part B of Medicare. To require such relinquishment or the imposition of higher non-optional premiums on Federal annuitants could have unintended repercussions on FEHB plans with the likelihood that annuitants would leave such plans increasing premium requirements for other covered persons and the Federal government as well.

In summary, we believe that coverage of the type included in H.R. 2470 should be optional for Federal annuitants both as to benefit and premium provisions. The FEHB program has served federal employees and annuitants effectively and economically since its inception in 1963. Indeed, the FEHB program, as the health insurance program for the nation's largest employer, has served as the model for state governments and private industry alike. While the goals of H.R. 2470 and S. 1127 are laudatory, the well-seasoned program under which federal employees and

annuitants are currently covered should not lightly be disturbed. The FEHB program is not perfect, and perhaps from time to time may require fine-tuning by Congress or OPM, but nonetheless we do not feel that wholesale changes in the law are warranted. Thus we urge the Committee in its consideration of these important measures to assure that the FEHB program is not adversely affected and can continue to meet the needs of federal employees and annuitants as effectively and efficiently as it has in the past.

Thank you for the opportunity to present our views.

TESTIMONY OF KAISER FOUNDATION HEALTH PLAN, INC.
SUBMITTED TO THE SUBCOMMITTEE ON COMPENSATION
AND EMPLOYEE BENEFITS
OF THE COMMITTEE ON POST OFFICE AND CIVIL SERVICE
ON THE RELATIONSHIP BETWEEN
MEDICARE CATASTROPHIC COVERAGE AND
THE FEDERAL HEALTH BENEFITS PROGRAM

Mr. Chairman, members of the Subcommittee, I am Robert J. Erickson, Senior Vice President and General Counsel of Kaiser Foundation Health Plan, Inc.

Kaiser Foundation Health Plan, Inc., its 11 subsidiaries, Kaiser Foundation Hospitals and 12 independent Permanente Medical Groups comprise the Kaiser Permanente Medical Care Program. The Program is an economically self-sustaining organized health care delivery system that provides health services on a prepaid, direct service basis to over five million members in California, Oregon, Washington, Hawaii, Ohio, Colorado, Texas, Maryland, Virginia, Connecticut, New York, North Carolina, Georgia, Kansas, Missouri, Massachusetts, and the District of Columbia. Our Health Plan members receive services through twenty-eight of our hospitals, more than 140 medical office locations, more than 6,000 contracting physicians and over 51,000 employees.

The Kaiser Permanente Medical Care Program has participated in the Federal Employees Health Benefits Program ("FEHBP") since its inception. In 1987, fourteen Kaiser Permanente Plans have qualified as participating carriers, and the total number of Federal employees, annuitants and their dependents enrolled in these Plans exceeds 460,000. The Northern California and the Southern California Regions of Kaiser Foundation Health Plan, Inc. are the two largest comprehensive plans in the FEHBP and are two of the "Big Six" plans which are used to determine the amount of the Government contribution. The government contribution for 1988 will increase by thirty-one percent, but the rate increases of the two Kaiser Permanente plans averaged only seven percent. These reasonable rate increases attest to the efficiency of managed care systems, even when utilization and the rate of inflation of health care are increasing. Many of the other HMOs participating in the FEHBP had similar rate increases.

All Kaiser Permanente plans provide 365 days of inpatient care to federal employees. There are no limits on covered inpatient care or covered physicians services. All Plans furnish prescription drugs at a charge of between $1 and $5 per prescription unit or refill. Only one of those plans has a deductible (of $50). All Kaiser Permanente Plans provide home care services. Kaiser Permanente Plans do not have substantial coinsurance on hospital or medical services (one low option plans in the FEHBP requires a twenty percent copayment, subject to a maximum out-of-pocket cost of $600). But even if a federally-qualified HMO such as Kaiser Permanente imposed

copayments, the total of such payments could not exceed two times the annual premium. This builds a "catastrophic cap" into any qualified HMO's coverage. Federal members of Kaiser Permanente have almost all of the catastrophic coverage that the proposed legislation would provide.

This Committee is considering the impact on federal annuitants of a bill that would provide catastrophic coverage for Medicare beneficiaries. The proposed plan would place a cap on a beneficiary's out-of-pocket expenses for covered services. Once the expenses incurred by the Medicare beneficiary exceeded the cap, catastrophic coverage would pay one hundred percent of the costs of covered services. We believe that catastrophic coverage is important to protect Medicare beneficiaries against extremely costly, uncovered hospital bills and medical procedures. However, we are concerned with the impact of the proposed legislation on beneficiaries enrolled in the Federal Employees Health Benefits Program.

The following factors are relevant in considering the relationship between the FEHBP and Medicare catastrophic coverage:

1. The benefits negotiated by OPM provide extensive catastrophic coverage;

2. The coverage provided to Medicare-eligible federal

annuitants by the HMOs participating in the Program, with minor exceptions, equals or exceeds the coverage established by the proposed Medicare catastrophic coverage;

3. The proposed means of financing the catastrophic coverage increases the cost of coverage to the Medicare-eligible federal annuitants without any appreciable increase in benefits; and

4. The Medicare-eligible federal annuitants will be taxed more heavily for this coverage than beneficiaries who receive Social Security retirement benefits.

We believe that the inequities created for Medicare-eligible federal annuitants under medicare catastrophic coverage can be ameliorated by adding a Medicare supplemental policy to the choices available to Federal employees under the FEHB Act. There is no authority under existing law for OPM to negotiate a contract that would provide supplemental benefits for Medicare-eligible federal annuitants. As a consequence, Medicare-eligible federal annuitants must select one of the 500 available options and "overpay" for the benefits provided under the FEHBP plans. By authorizing OPM to contract for Medicare supplemental coverage, the excess coverage and the expense of "overpaying" can be eliminated. The Medicare-eligible federal annuitant could choose among competing plans for benefits that supplement Medicare, based upon such competitive factors as price and services. A well-conceived Medicare supplemental plan, that receives the thorough review that OPM traditionally gives to health benefits

contracts, will protect the Medicare-eligible federal annuitant and will enable HMOs and any other carrier to provide a more suitable product.

In addition, if OPM was authorized to contract for supplemental policies, it would facilitate the enrollment of Federal Medicare beneficiaries in the Medicare "risk-contracting" program.

In 1983, Congress passed legislation designed to encourage Medicare beneficiaries to join HMOs through the "risk contracting" mechanism. It has become clear that the FEHBP and the Medicare risk concept do not interface effectively. The law requires risk basis HMOs to enroll all new Medicare beneficiaries under the risk contract. However, no effective mechanism exists to enroll federal members in the risk contract and there is little incentive for them to enroll.

Medicare-eligible federal annuitants are unlikely to enroll in a risk contract because they would have to sever their relationship with the FEHBP and lose the right to re-enroll in the event they became dissatisfied with the HMO. (They do have the alternative of remaining in the FEHBP and enrolling under the risk contract, but they would have to pay the risk contract premium in addition to their FEHBP premium and their Part B premium. There is little likelihood of their joining a risk contract under these circumstances.) We understand that OPM has prepared a regulation that would allow suspension, rather than termination, of the

federal enrollment if a Medicare-eligible federal annuitant elected coverage under a risk contract. This is a necessary step in solving the failure of the two Programs to interface, but is not a complete solution.

The most significant problem is that the FEHBP member would have to relinquish the government contribution if he or she enrolled in a risk contract. Why should the Medicare-eligible federal annuitant have to take an action that will result in the loss of an important vested right?

If the risk member withdraws from the risk contract by giving notice to the HMO, the risk member cannot become a "cost basis" member of the plan. That person would have to receive services on a fee-for-service basis under the traditional Medicare system. Medicare-eligible federal annuitants, who have severed their relationship with the FEHBP, probably could not remain a member of the HMO. The option of enrolling as a direct pay member would not be available because the enrollment would have to be under a risk contract. A Medicare-eligible federal annuitant who had been a member of the plan for twenty, thirty or even forty years might be forced to sever a relationship with providers.

The coordination between Medicare and the FEHBP is a complex issue, but it can be solved and needs to be solved in the near future. It is necessary to evaluate the FEHBP, Medicare risk contract and the proposed catastrophic coverage to find a means of making all three meaningful to Medicare-eligible federal annuitants.

We recommend OPM be authorized to contract for Medicare supplemental or "wrap-around" policies through an amendment to 5 USC Sections 8902 and 8903. OPM should be given discretion in selecting the benefits that would be made available under the option. However, as a minimum, each plan would have to provide catastrophic coverage in the form of a cost cap on copayments or deductibles that does not exceed the catastrophic cap set by the proposed medicare catastrophic coverage. The FEHB Act could be amended to mandate the additional coverage contemplated by the proposed medicare catastrophic coverage as part of the minimum level of benefits. By adopting this proposed change, the Committee can solve the problems identified at these hearings and provide OPM with ample leeway to negotiate benefits which meet the minimum requirements of this bill.

Thank you for the opportunity to submit these comments. We will be happy to work with this Committee to develop solutions to the problems we have discussed.

TESTIMONY OF

ROBERT L. WHITE, NATIONAL PRESIDENT

NATIONAL ALLIANCE OF POSTAL AND FEDERAL EMPLOYEES

Mr. Chairman, Members of the Subcommittee:

We greatly appreciate this opportunity to offer testimony on H. R. 2470, the Medicare Catastrophic Protection Act and S. 1127, the companion measure in the Senate.

The National Alliance of Postal and Federal Employees is gravely concerned about the possible consequences of legislation designed to alter federal health benefit plans. We have worked diligently to insure that the Alliance Health Benefit Plan provides each of our enrollees with the optimum level of health care protection.

The basic objectives of the Catastrophic bill appear to be acceptable. But federal retirees, of whom we have a great many in our plan, will be forced to bear the unfair burden of increased premiums to pay for benefits already being provided. Senior citizens are being unfairly penalized by this bill as it now stands. With such a large number of people being subjected to what would amount to an abuse, we must urge that this bill be amended to benefit federal and other contributory retirees.

The Medicare Catastrophic Protection Act, as we understand it, was designed to fill some of the gaps in Medicare coverage that have resulted in our elderly spending most of

their income on health care. The overall effect of this had left elderly persons not much better off than when the Medicare program was established. For despite the assistance provided by Medicare and Medicaid, out-of-pocket health care expenses for the elderly have skyrocketed. In 1977, out-of-pocket health care expenditures by the elderly was found to have totaled $12.7 billion; by 1984, this figure had reached $30.2 billion - an increase of %138 in seven years. Clearly, something must be done to curtail this enormous financial burden on citizens living mostly on a fixed income.

We believe that the intent of this legislation has somehow been frustrated by allowing a duplication of benefits to federal retirees. Many retirees believed that this bill would take care of all of their medical needs and problems. We now realize that only acute catastropic care is covered and the problem of nursing home care and home health care remain.

Additionally, this bill, if not amended, would likely dramatically disrupt our health plan, the National Alliance Federal Health Benefits Program. By offering to this group benefits which they already receive in our plan and other Federal Employees Health Benefits Plans, there will be little need for these approximately five million persons to remain in the FEHBP. This is not a benefit to anyone. To

offer identical coverage they already have under FEHB and force them to pay for something they already have will have the devastating effect of dismantling many of the Federal Health Benefit plans. This would be to the devastation of other enrollees who have not reached retirement age.

It is reasonable to assume that retired enrollees would simply abandon their FEHB coverage and opt for Medicare coverage alone.

Since the success of all Health plans rely on the number of their enrollees, it is difficult to predict the overall effect of driving out several million retirees from the ranks of Federal Employees Health Benefit Plans. But one might guess that many of the plans would be ravaged and brought to ruin.

We support the improvement in Medicaid benefits for the low-income elderly. If states are required to provide limited benefits - to cover medicare premiums, deductibles and other cost sharing requirements for all elderly persons with incomes below the poverty line, this would be a plus for persons in this group. We also support the element in the bill which protects the income and assets of the spouses of Medicaid-eligible nursing home residents.

About prescription drug coverage. Because we feel it is imperative that prescription drug coverage be provided to all our enrollees, we have incorporated this aspect of

health care coverage in our plan. The cost of prescription drugs has skyrocketed and the elderly pay more for this service than any other group. Here again, the Medicare Catastrophic Protection Act duplicates this benefit. The National Alliance was among the first to recognize the need for prescription drug benefits, and we moved swiftly to implement the idea. We believe our plan offers one of the very best prescription drug benefits. H. R. 2470 offers 80% drug coverage after the patients incur $500.00 in drug costs per year. There are altogether too many duplications of benefits for retirees for this bill not to drive out millions of enrollees from the FEHBP.

Mr. Chairman, in light of the unfair burden this legislation would impose on federal retirees and their survivors by forcing them to bear a disproportionate share of the cost of extended Medicare benefits which duplicate health protection they already have, the National Alliance must go on record as being opposed to this legislation.

The inequity is great and the relative benefits are small compared to the additional damage it will do to Federal Employees Health Benefit Plans in general.

We hope that this committee will find the means to modify this legislation and work with the Senate in time to stop the impact this bill would have on government annuitants. This proposal as well as any other Medicare measure should be addressed and resolved in the context of the more comprehensive changes and overall effect it will have on Federal Employee Health Benefit Plans.

Thank You.

NATIONAL ASSOCIATION OF POSTAL SUPERVISORS

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Office of President
RUBIN HANDELMAN

October 1, 1987

Honorable Gary L. Ackerman
Chairman, Subcommittee on Compensation
and Employee Benefits
511 House Office Building Annex 1
Washington, DC 20515

Dear Mr. Chairman:

The National Association of Postal Supervisors thanks you for allowing us the opportunity to submit the enclosed testimony with regard to H.R. 2470, the Medicare Catastrophic Protection Act, as well as S. 1127, the companion measure in the Senate.

We have, as you will note in our testimony, some serious concerns with this critical legislation.

We again thank you for this opportunity in addition to your continued consideration and support.

Sincerely yours,

Rubin Handelman
President

RH:met
Enclosure

Thank you for inviting the National Association of Postal Supervisors to submit written testimony on the Medicare Catastrophic Protection Act as well as the pending Senate legislation. We appreciate the Committee's interest in hearing our comments concerning the bills' effect on federal and postal retirees participating in the Federal Employees Health Benefits (FEHB) Program.

The National Association of Postal Supervisors supports the intent to legislate catastrophic health care protection for the elderly. The Medicare Catastrophic Protection Act and the companion measure in the Senate, however, raise some concerns that we share with other organizations that sponsor health benefit plans under the FEHB Program.

Of primary concern to NAPS is the inequity created under the financing provisions of both the House and Senate versions of the Medicare catastrophic protection legislation. The supplemental premium established under the Medicare Catastrophic Protection Act and that established under the Senate legislation are based on taxable income. Although the tax-based formula for calculating supplemental premium differs in the House and Senate versions of legislation, the results are the same for federal and postal retirees. At identical income levels, the federal and postal annuitant whose pension is fully taxable would pay more for catastrophic health insurance protection than the private sector retiree whose annuity is fully or partially tax-exempt Social Security income.

To compound the problem created by the bills' financing provisions, the level of coverage established by both the House and Senate legislation duplicates, and in several cases is not as extensive as, the health benefits coverage provided federal retirees enrolled in the FEHB Program.

Many plans in the FEHB Program - including the Postal Supervisors Health Benefit Plan - offer federal and postal retirees insurance coverage to supplement those benefits paid by Medicare (either Part A, Part B, or both). When an annuitant enrolled in the Postal Supervisors Health Benefit Plan is also eligible for benefits under Medicare, our Plan will coordinate its benefits with those paid by Medicare for the same covered expenses and will pay for certain expenses not covered by Medicare. Through this coordination of benefits, the federal and postal retiree receives comprehensive insurance protection. The plans in the FEHB Program have variations in the benefits provided under the coordination of benefits provisions, but many - like ours - offer Catastrophic Protection Benefits with out-of-pocket expense maximums and 100% prescription drug reimbursement provisions. Likewise, many waive the plan deductibles - both hospital and major medical - for those retirees enrolled in Medicare Part A and Part B and pay, through their coordination of benefits mechanisms, the Medicare Part A and Part B deductibles.

The coverage proposed in the Medicare catastrophic legislation is not as comprehensive (with the possible exception of skilled nursing care facility coverage, respite care coverage, and community spouse benefits) as that provided federal and postal retirees under most plans in the FEHB Program. Consequently, if coverage under the Medicare catastrophic legislation is mandatory, the federal annuitant suffers not only because the supplemental premium for Medicare catastrophic protection will be higher than that paid by private sector retirees, but because the level of coverage will not be as broad as that available under the FEHB Program.

Although the Postal Supervisors Health Benefit Plan has one of the lowest percentages of retired enrollees by comparison to Blue Cross and Blue Shield, Aetna, and most of the other employee-organization sponsored health plans in the FEHB Program, the impact of the Medicare legislation will be felt if Medicare catastrophic protection coverage becomes mandatory. Federal and postal annuitants could not afford to pay for both full Medicare catastrophic protection coverage and FEHB plan coverage. As a result, Medicare-eligible retirees would terminate their enrollments in the FEHB plans. Current regulations prohibit an annuitant from re-enrollment in the Program once coverage has been terminated.

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Because federal retirees who are enrolled in Medicare create savings to the FEHB plans in which they are enrolled through their entitlement to Medicare benefits, this savings to the plans is available to offset overall claims expenses. In other words, when Medicare as the primary insurer pays its benefits first, most plans under the FEHB Program are liable for a reduced benefit amount which, when added to Medicare's benefits, will in many cases cover the expenses in full. The savings created to the FEHB plan is the difference between what the plan's liability would have been in the absence of Medicare coverage and the reduced benefit liability as a result of coordinating benefits with Medicare.

If these same federal annuitants withdraw from the FEHB plans, the savings are no longer there to offset the plans' other claims expenses. The impact is apparent. Those plans that realize substantial Medicare savings could compensate for the loss only by increasing premiums to other plan enrollees. Obviously, under those FEHB plans where Medicare-eligible annuitant populations are high, the impact is greater than under those plans where only a small percentage of total enrollment is comprised of annuitants eligible for Medicare.

To conclude, we cannot support current Medicare catastrophic legislation that forces federal retirees to pay a disproportionate share of the premium cost for coverage and that places this kind of unfair financial burden on the federal and postal annuitant population. Nor do we endorse Medicare catastrophic legislation that would adversely impact and de-stabilize the FEHB Program.

We recommend that premium computations for Medicare catastrophic protection be re-evaluated and that a revised formula be established so that federal and postal retirees are not penalized with higher costs. We also recommend that Medicare catastrophic protection coverage be a voluntary program so that federal and postal retirees have the freedom to choose which health insurance coverage is best suited for their needs.

We hope that our written testimony as well as that provided by other interested organizations will help correct the problems current Medicare catastrophic protection legislation will cause federal retirees. We again thank you for the opportunity to provide our comments.

National Federation of Federal Employees

James M. Peirce • President
Abraham Orlofsky • Secretary Treasurer

In reply refer to: _____

October 8, 1987

The Honorable Gary L. Ackerman
Chairman
Subcommittee on Compensation and Employee Benefits
Committee on Post Office and Civil Service
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Thank you for inviting the National Federation of Federal Employees (NFFE) to submit a written statement concerning the effects of the proposed Catastrophic Protection Acts (H.R. 2470 and S.1127) on Federal annuitants who are enrolled in the Federal Employees Health Benefits Plan.

The National Federation of Federal Employees is the oldest and largest independent union of Federal workers. Organized in 1917, NFFE has worked for 70 years for a better America through dedication to the betterment of the Federal service. In the spirit of this longstanding quest for improving the lot of Federal workers, I commend you and the Subcommittee for undertaking a review of the devastating financial consequences for Federal retirees of certain provisions of the catastrophic measures now before the Congress.

At the outset, Mr. Chairman, I want to emphasize that the National Federation of Federal Employees strongly supports the objectives of the Catastrophic Protection Acts. We stand squarely behind the efforts to improve the protection afforded older Americans against the devastating financial effects of medical costs associated with a catastrophic illness. We must not, however, overlook the unintended consequences of the particular aspects of the pending bills that fail to recognize the unique way in which Federal annuitants are taxed, nor the duplicative premium costs for catastrophic protection already provided in the Federal Employees Health Benefits Program. The National Federation of Federal

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NFFE National Vice Presidents:
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Region 2, Robert E. Estep, Jr., Chambersburg, PA
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Region 4, Richard E. Reiman, Terlton, OK
Region 5, William P. Davis, Parker, AZ
Region 6, Gene Needham, Port Hueneme, CA
Region 7, Charles Shelton, Sitka, AK
Region 8, Jan Lambert, Kansas City, MO
Region 9, Sheila Velazco, Muncie, IN

Employees stands ready to assist the Subcommittee in attempting to correct these inequitable, and unintended, provisions as the measures evolve through the legislative process.

Concerning the Federal Employees Health Benefits Program, we believe it would be unwise to attempt to fashion specific remedies for the problems that would be caused by the Catastrophic Protection Acts until we know precisely the final version of those Acts and are able to assess, with reasonable specificity, the real effects on FEHB plans. Perhaps the wisest course of action at this time would be to seek a delay in the effective date of the Medicare proposals with respect to Federal annuitants. This would provide the time necessary for the Subcommittee to develop, in concert with the representatives of employees and retirees, appropriate solutions.

I would like to take this opportunity to apprise the Subcommittee of the innovative revision to NFFE's High Option Health Plan for 1988 which provides true Catastrophic coverage for 100% of covered charges after the required deductible has been reached. For a Medicare-eligible annuitant with both parts A and B, the entire deductible will be waived. In addition, this option provides a prescription drug benefit that can be used either through local participating pharmacies or through mail order services. This option should be very attractive to annuitants with full Medicare coverage.

Again, thank you for seeking the views of the National Federation of Federal employees. We look forward to working with you.

Sincerely,

James M. Peirce
President

JMP:dg

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October 6, 1987

The Honorable Gary L. Ackerman
Chairman
Subcommittee on Compensation and Employee Benefits
Committee on Post Office and Civil Service
511 House Office Building Annex 1
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Ackerman:

Thank you for inviting the National League of Postmasters to submit a written statement concerning the effects, on Federal annuitants, of the proposed Catastrophic Protection Acts (H.R. 2470 and S. 1127).

First, Mr. Chairman, I want to commend you and the Subcommittee for undertaking a review of this most important issue. The National League of Postmasters strongly supports the objectives of the Catastrophic Protection Acts. The proposals to protect older Americans from the devastating effects of unforeseen, and largely unaffordable, medical expenses are unarguably well-intentioned. Unfortunately, as proposed, they would unintentionally place an unfair financial burden on Federal civilian retirees (as well as military retirees and certain retired employees of state and local governments), due to the unique way in which their annuities are taxed and to the duplicative expenses they would incur, given the catastrophic protection already provided through most plans in the Federal Employees Health Benefits Program. Therefore, the National League of Postmasters would urge the Subcommittee to pursue with vigor every possible means of correcting these inequitable, and clearly unintended, features of the bill pending in the Senate and, if necessary, in conference.

With regard to the Federal Employees Health Benefits (FEHB) Program, we strongly suggest that extreme caution be exercised in fashioning new measures to offset or mitigate, the effects of the Medicare Catastrophic expansion proposals. It should be noted that, notwithstanding the new catastrophic initiatives, some FEHB plans provide greater value than others for Medicare-eligible retirees. For example, the Postmasters Benefit Plan (PBP) incorporates in its Standard Option benefit design, many features that should appeal to the Federal annuitant with Medicare and approximately forty percent of the option's enrollees are retirees. The PBP

Standard Option consistently has been one of the lowest cost plans in the FEHB program and this trend will continue in 1988. Much of the potential problems of duplicating premiums could be diminished by Federal Medicare-eligibles relocating, voluntarily, to lower cost plans -- at least as an interim solution.

We also suggest that the Subcommittee seek a delay for Federal retirees in the effective date of the Medicare proposals (should the inequitable provisions become law) to permit time for an orderly study of the effects on FEHB participants. Any statutory remedy in the FEHB program should not be a quick-fix for an immediate problem but should be part of a well-conceived strategy for continuing the quality medical care which Federal employees and retirees now enjoy.

Again, I thank you for seeking our views and pledge the full support of the National League of Postmasters to you and the Subcommittee in pursuing a solution.

Sincerely,

Ron Swisher
President
National League of Postmasters

RDS:cab

WRITTEN TESTIMONY

OF

LARRY WALIGORA

MANAGER OF

NATIONAL RURAL LETTER CARRIERS' ASSOCIATION

HEALTH BENEFIT PLAN

It is a pleasure to share with you our concerns about the Medicare Catastrophic Protection Act of 1987, and the adverse effects this legislation would have on Federal retirees.

The Congress, through legislation passed in 1959, created the Federal Employees Health Benefit (FEHB) Program. With some fine tuning along the way, it has been an outstanding and overwhelming success as the largest employer sponsored health plan in the world. The Medicare Catastrophic Legislation which we are offering testimony on today would begin to seriously disrupt and dismantle this program which serves some 5 million Federal employees, retirees and surviving spouses, because it would simply offer those individuals identical coverage to that which they already have under the FEHB Program and force them to pay for something from which they will get no benefit. We predict that most Federal retirees will leave the Federal Employee Health Benefits Plan opting, instead, for only Medicare coverage. The proposed legislation would, thus, dramatically change and reduce the size of the universe of enrollees who are participating in the Federal Employee Health Benefits Program.

We also object to the catastrophic premium schedule in the proposed legislation because it is based on taxable income. That creates substantial inequities since Federal retirees

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receive a pension from the Civil Service Retirement Trust Fund and all of the money a Rural Carrier annuitant receives would be considered taxable income under this legislation. An employee, who retired from the private sector under similar circumstances and length of service, would have a vastly different premium calculation for the same benefits. As an example, the average Civil Servant retiring at 62 years of age draws a monthly annuity of about $14,000 per year all of which would be used for the calculations of the catastrophic premium. Conversely, someone retiring under a private pension plan at age 62 with about $14,000 in retirement income would most likely be receiving $6,000 of the total in Social Security benefits none of which would be utilized in the calculation for setting the premium under this legislation.

Let's examine the double coverage issue. Under our Federal Health Plan for the catastrophic provision to kick in, a member must accrue $1,000 in out-of-pocket expenses. Under the proposed Medicare Catastrophic legislation, a person must accrue $1,700 in out-of-pocket expenses. In the prescription drug area, our Federal plan picks up 100 percent of the cost for prescription medication if our retired member is also covered by Medicare Part B. Under the proposed Medicare legislation, a person must accrue $500 in prescription drug payments before Medicare would cover 80 percent of the cost of medication. Under the Rural Carrier Plan, we waive the hospital deductible for Medicare eligible people. Under our plan, we waive the

major medical deductible for retired members enrolled in Part B, and additionally we pay the two Medicare deductibles, both hospital (Part A) and medical (Part B).

Let's look at the issues of changing the overall composition of the FEHB Plan members and what that would do to the various plans that participate in the program and, likewise, to the Federal Government's share of the cost of the Program. If the legislation being considered becomes law and contains a premium structure similar to the current proposal with no allowance for the double coverage of Medicare eligible Federal retirees, then it is our prediction that massive numbers of retired enrollees will simply abandon their FEHB Plan and opt instead for Medicare coverage alone. Since Medicare is already the primary payer of medical expenses for these retired members, with the FEHB Plan serving as a so-called Medicare supplement, it would seem reasonably certain that our prophecy will be fulfilled.

This, in turn, will cause a tremendous change in the demographics of each FEHB plan and will result in a tremendous premium increase to remaining enrollees. Thus, in all likelihood, the Government contribution to the program would also increase substantially under the current FEHB funding mechanism. The only enrollees left to support the program would be active employees, those retired but not yet 65 years old and those retired, over age 65, with no Medicare eligibility. It would

be a tremendous financial hardship for those plan members comprising the latter two categories to pay the resulting high FEHB Plan premiums on their fixed incomes.

We think that there are some things that need to be done to remedy the adverse impact of the proposed Medicare catasrophic legislation on Federal retirees. Such remedies are not simple, but, rather complex. First, some relief must be given to Federal retirees in the computation of the Medicare catastrophic premium to bring the cost in line with their private sector counterparts. Secondly, something must be done to eliminate the double coverage that Federal retirees will be forced to pay for under the Medicare Catastrophic Bill. We would like to suggest very strongly that the Medicare catastrophic coverage be truly voluntary in so far as participation. For example, make the catastrophic coverage a separate and distinct part of the Medicare Program like Parts A (Hospital) and B (Medical) already are. Such a voluntary nature would at least ensure that Federal retirees with FEHB coverage could make an educated decision on what health coverage best suited their individual situations. However, if the Medicare catastrophic coverage remains mandatory as under the House version or is attached to Part B of Medicare as proposed by the Senate, there is no true voluntary choice. So, we would hope that the members of the Subcommittee could strongly urge that the voluntary nature of the coverage be considered in conference.

Mr. Chairman and Members of this Committee, we are very grateful that you have willingly taken your time to hold a hearing on these issues which are of vital importance to the members of the National Rural Letter Carriers' Association and the Rural Carrier Benefit Plan. Thank you very much for including our testimony in your review of this issue.

STATEMENT OF

ROBERT M. TOBIAS

NATIONAL PRESIDENT

NATIONAL TREASURY EMPLOYEES UNION

Thank you for the opportunity to express the view of the National Treasury Employees Union on H.R. 2941, the Medicare Catastrophic Protection Act of 1987.

NTEU certainly supports the intent of this legislation. We believe that action to provide catastrophic health care for the elderly is long overdue. Most federal insurance plans, in fact, have provided catastrophic coverage for employees and retirees alike for many years, and we feel strongly that this coverage should be available to the Medicare-dependent population.

There are, however, problems in this legislation that are unique to the federal employee. First of all, the bill contains a supplemental premium that is based upon tax liability. Because federal pensions are fully taxable, whereas social security benefits are exempt from taxes up to a certain income level, federal retirees would pay more for catastrophic coverage than their private sector counterparts.

In H.R. 2941, a supplemental premium would be paid by all Medicare beneficiaries with federal income tax liability. The premium, which would be administered through the income tax system, would be based on adjusted gross income, as defined for federal income tax purposes.

This premium structure has a very different effect on federal retirees than on social security recipients. Social Security recipients do not incur tax liability on their

pensions unless their total income level is above $25,000 for a single individual, or $32,000 for a married couple. The amount to be taxed is the lesser of one-half of social security benefits for the year, or one-half of excess over the base amount.

A federal annuitant, on the other hand, pays taxes on his or her entire pension, regardless of total income. This means that a federal retiree's entire income would be subject to the formula for the supplemental premium. Under H.R. 2941, a civil service retiree with an annuity of $600 per month would be subject to a supplemental premium of $90 per year. A person with a social security survivor benefit of $600 per month would incur no supplemental premium. At virtually all levels of income, federal retirees would pay more for the extended Medicare coverage through the supplemental premium than their private sector counterparts at identical income levels.

This situation points out, once again, the severe inequities that exist between social security and federal pensions. The best solution to this problem would be the enactment of legislation to treat federal pensions the same as social security for tax purposes. This would be a fair and equitable change in the law. It is simply wrong that those who spend their careers in federal service are put a at disadvantage, as opposed to other retirees, in retirement.

For the purposes of H.R. 2941, an amendment should be adopted that would direct OPM, or another related agency, to

calculate a separate supplemental premium for federal and postal retirees, based on the fact that Social Security benefits have different tax treatment than federal benefits.

The premium inequity existing in H.R. 2941 is made even worse by the fact that most federal retirees already receive catastrophic health care coverage through the Federal Employee Health Benefits program. Most of the 440 different plans participating in FEHB provide catastrophic coverage to both employees and retirees. Federal retirees, therefore, will paying more than any other participants for benefits that are largely duplicative. While many Medicare enrollees could drop their Medigap policies if extended Medicare coverage becomes available, federal annuitants would be afraid to do so, for once a retiree drops out of FEHB, re-enrollment is prohibited.

However, the cost of continuing both Medicare and an FEHB plan would be prohibitive for many retirees, and they might be tempted to drop the more expensive, but more extensive, FEHB. Should this happen, it would have adverse effects on the federal budget. It would substantially increase the amount of money needed to fund Medicare to cover the federal retirees who discontinue FEHB. It would also raise the premiums all plans must charge the remaining participants, employees and retirees alike. This would cost the government because the government provides a 60% co-payment, based on the average of the "Big Six" plans.

It is, therefore, to everyone's advantage to address the problems inherent in this legislation. There are a variety of potential solutions to these problems. FEHB plans, through legislation, could be allowed to provide Medicare Supplemental (Medi-gap) plans for their retirees. Congress could increase the government FEHB co-payment to retirees from 60% to 75%, essentially reimbursing retirees for duplicate coverage. A third solution would have a yearly entitlement reimburse the FEHB carriers for whatever is included in catastrophic coverage. This would end the duplication, and allow the plans to provide additional coverage for the increased money that federal retirees are spending. There are a variety of solutions; the key is to find a way to make this bill equitable for all the elderly.

Once again, thank you, Mr. Chairman, for holding these hearings. I am hopeful that this effort will serve to point out the seriousness of the problems with this legislation, and to provide some potential solutions. Through these efforts, I hope we can find a way to move this important legislation forward in a manner that is fair and equitable to all our retired citizens.

SF/slw/2517L

STATEMENT OF

THE MUTUAL OF OMAHA COMPANIES

ON

THE IMPACT OF PROPOSED MEDICARE CATASTROPHIC LEGISLATION ON THE FEDERAL EMPLOYEES HEALTH BENEFIT PROGRAM (FEHBP)

To The

COMPENSATION AND EMPLOYEE BENEFITS SUBCOMMITTEE

of the

POST OFFICE AND CIVIL SERVICE COMMITTEE

U.S. HOUSE OF REPRESENTATIVES

October 7, 1987

Prepared By:
Robert S. Murphy
Second Vice President
Group Government Contracts

Impact of Medicare Catastrophic Legislation on the Federal Employees Health Benefit Program

On behalf of the Mutual of Omaha Companies, we appreciate this opportunity to present our comments regarding the proposed Medicare Catastrophic legislation and its resulting effect on the Federal Employees Health Benefit Program (FEHBP). Mutual of Omaha is one of the largest providers of individual, family, and group health insurance and has provided health insurance to Federal employees since 1942. We currently underwrite 11 plans in the FEHBP with a combined enrollment of 244,000. Approximately one third of these are retirees.

Most of our comments will focus on the impact of proposed Medicare catastrophic legislation on the FEHBP. The hardships and inconsistencies of double coverage and double premiums, tax inequity and related problems for federal employees under the proposed legislation have been well-covered by witnesses who have testified before the subcommittee, and we support their views. However, we do want to touch briefly on some of those subjects and other issues related to them, especially the competitive advantage now enjoyed by health maintenance organizations (HMOs) in the FEHBP.

We have serious concerns about the two catastrophic health care bills now awaiting action by the Senate (H.R. 2470 & S. 1127). The crux of our concern is that neither of the bills addresses the real catastrophe confronting an increasing number of our "greying Americans".

The catastrophe older Americans fear most is the possibility of facing the enormous cost of long-term health care, in a nursing home or through home health care.

It is a frightening prospect for our senior citizens to spend their twilight years contemplating the total depletion of their financial resources in order to meet such expenses or to become dependent upon others to do so. With the exception of the drug benefit, the type of coverage contained in the pending bills is already available and, indeed, carried by many of our elderly citizens through private insurers. Mutual of Omaha has added these benefits to existing Medicare supplement policies at no charge to the insured.

Long-term care is a different story. We, at Mutual of Omaha, are diligently working on plans that would be within the financial reach of many Americans. For others it will be beyond their reach. It would be a travesty if Congress offers our citizens health care coverage which is already available to them, depleting, in the process, whatever federal monetary resources may be needed for assistance for the true catastrophe facing many senior citizens - long-term care. When Congress squarely addesses that problem, the well of federal funds may be dry.

The potential impact of the Medicare Catastrophic legislation on FEHBP needs to be viewed in the perspective of overall problems that have been developing in FEHBP in recent years. Whether the proposed Medicare Catastrophic legislation is adopted or not, revisions are needed in the FEHBP with particular focus on retirees.

Annuitants and FEHB

We estimate that at least 70% of the annuitants covered by the FEHB plans that we underwrite are eligible for Medicare. Between the coordination of coverage provided by the FEHBP and that currently provided by Medicare, these members receive virtually 100% coverage for their health care expenses. The combined coverage usually extends to prescription drugs. However, since Medicare is the primary payor, it pays a significant portion of the health care services provided to these members. These members are very desirable participants in the health plans since they help keep the costs lower for all of the members in the health plan. Let us review an example from one of our plans.

In 1986, the annual claim cost per member under age 65 was approximately $3,000. With the benefits currently provided by Medicare, the annual claim costs for members age 65 and over was approximately $935. Without the age 65 and over members, all

other members of the health plan would need to have their premiums increased by at least 50% in order to cover their own claim costs.

The withdrawal of Medicare beneficiaries from FEHBP plans becomes a major concern when the mandatory provisions of the House Medicare Catastrophic bill are considered. It would be burdensome and costly for Federal retirees to carry both their FEHBP coverage and Medicare. Since they are not allowed to waive Medicare under the current proposals, many of them will drop their FEHB plans. A large withdrawal of Medicare retirees from the FEHBP would have an adverse affect of those remaining. Furthermore, this impact would not fall evenly throughout the FEHBP. The percentage of retirees differs from plan-to-plan. The two plans that have a direct impact on the government's contribution to FEHBP cover approximately 65% of all retirees, i.e., Blue Cross and Aetna.

Adverse Selection and FEHB

The withdrawal of Medicare retirees from FEHBP would worsen problems that have been developing in the FEHBP program over the past few years. These problems are the result of transfers that

are being made during open season. In short, those individuals who feel they will need medical care will look for a plan with good benefits and those individuals that do not foresee any immediate medical needs will look for a plan with the lowest cost. As a result, plans with above average benefits have found that they are losing the younger, healthier employees and attracting those with medical needs. The needs of the less desirable members, and the resulting cost, thus are passed on to or assessed against those members who are more desirable i.e. who incur less cost for fewer health requirements. In insurance terminology, this is referred to as "adverse selection". In more simple terms, it means that individuals will make a choice that is in their best interest and detrimental to other participants, and to the plan in general.

Retirees without Medicare coverage will generally have higher expected health needs and therefore seek plans with good benefits. However, the plan they are in will pay out more in benefits than it will receive in premiums without Medicare as the primary payer. The problem would be lessened, to a large degree, if such retirees were evenly distributed throughout the FEHBP. Unfortunately, they are concentrated in a small number of plans as noted above. This inequity could also be lessened if more flexibility were allowed in the premiums for the plans

and for the government. In the private insurance industry, there are usually separate classes for active employees, retired employees with Medicare, and retired employees without Medicare. Such a change, in the FEHBP would be a step toward lessening adverse selection and would require a corresponding change in the way the government contribution is determined. That is, a larger government contribution would be needed for those retirees without Medicare.

The Office of Personnel Management, and others, have expressed the need for comprehensive reform of the FEHBP because of problems and inequities in the current program. We support OPM's position in that respect and would point to the preferential treatment of HMOs in comparison to indemnity plans as an example. The significant increase in the number of HMOs admitted to the FEHBP over the past few years has had an impact on adverse selection. While these programs offer more choices to Federal employees, they presently have certain advantages over the traditional plans in FEHBP. For example:

- HMOs most often involve a need for an individual to change providers. This can be a barrier for someone with a long, established relationship with a physician. This is most often going to be the case with a retiree or someone with a history of medical problems. As a result,

HMOs have not had to accept an equitable share of retirees without Medicare and other individuals with known medical needs seeking good benefits.

- HMOs in the FEHBP are able to establish their premiums based upon their local area. For those that are in areas where health care costs are below the national average, they have an advantage when competing against traditional plans since these plans must set their rates based on their overall national experience. By the same token, HMOs in the higher cost areas have a more difficult time competing against the traditional plans. Accordingly, the result is that the traditional plans may compete more favorably in the higher cost areas thereby adding an element of selection that increases the cost of the benefits they are underwriting through no real fault of their own.

Some form of area rating would lessen this selection problem to a large degree.

We recognize that changes in the way premiums are set would cause some variations in cost among different plans and among different categories of participants in FEHBP. However, we believe such changes would be in the best interest of the FEHBP

in the long run and would "level the playing field" for all of the plans. In this regard, we note that OPM has awarded a contract for a comprehensive evaluation of FEHBP which includes an analysis of Medicare issues. We believe this is a positive step and are prepared to work with OPM in whatever way we can.

Conclusion

We are very pleased that you are holding a hearing on these issues which are of vital importance to the FEHBP. We have serious concerns about the so-called catastrophic health care legislation that passed the House (H.R. 2470) and the bill that is now awaiting action by the Senate (S. 1127). Our concerns are increased by the impact that these bills will have on federal employees who already have catastrophic coverage under the FEHB plans and the disastrous effect they would have on FEHB plans with high ratios of annuitants in their membership. We would urge you, in your considerations, to also focus on what we believe are the fundamental problems in the current program of which the retirees are a part. Toward this end, our Company looks forward to cooperating with this subcommittee to develop workable solutions.

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CRS REPORT FOR CONGRESS

PREMIUM EFFECT OF PROPOSED MEDICARE CATASTROPHIC LEGISLATION ON FEDERAL ANNUITANTS

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ABSTRACT

This paper examines two major issues related to the premium effect on Federal annuitants of proposed legislation to provide catastrophic coverage under Medicare. These issues concern (1) the larger Medicare supplemental premium Federal annuitants would pay compared to social security recipients because of the greater taxation of the Federal annuity, and (2) the premium overpayments that Federal annuitants covered by both Medicare and the Federal Employees Health Benefits Program would pay because of benefit duplication.

PREFACE

Numerous analysts in the Congressional Research Service contributed to the preparation of this paper including Beth Fuchs, David Koitz, Geoffrey Kollmann, Carolyn Merck, Jennifer O'Sullivan, and Raymond Schmitt of the Education and Public Welfare Division, and Gregg Esenwein and Alan Talley of the Economics Division.

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PREMIUM EFFECT OF PROPOSED MEDICARE CATASTROPHIC LEGISLATION ON FEDERAL ANNUITANTS

I. INTRODUCTION

This paper includes background information on the Medicare program, a summary of the relevant features of the proposed Medicare catastrophic coverage legislation, and a discussion of two major issues concerning the premium effect of the legislation on Federal annuitants who are covered by Medicare.

The first issue concerns Federal annuitants (and certain other retirees) who would pay a larger supplemental premium for the proposed Medicare catastrophic coverage than those retirees with pension income derived from social security benefits. The tax treatment of the Federal pension (most of which is treated as income subject to taxation) compared to the taxation of social security benefits (which, for the most part, are tax-exempt) means that the Federal annuitant's income and tax liability are larger than that of the private retiree with social security even though they may have the same amount of pension income. Since the proposed supplemental premium is determined according to income (adjusted gross income in H.R. 2470 and tax liability in S. 1127), the Federal annuitant would pay a larger supplemental premium than the private retiree with social security. Several hypothetical examples illustrating these differences in supplemental premiums depending on the type of pension income can be found in appendix 2 of this report. Medicare-eligible Federal annuitants and other retirees whose pensions are taxed to a greater extent than social security benefits would thus pay a disproportionate share of

the cost of Medicare's expanded benefits through their supplemental premium payments.

The second issue concerns the duplication and coordination of benefits between the Medicare program and the Federal Employees Health Benefits (FEHB) program. Since the FEHB program does not offer a Medicare supplemental policy option to its Medicare-eligible Federal annuitants, the FEHB coverage that is currently available to them duplicates Medicare's coverage to some degree. This duplication would be even greater if the Medicare program were expanded to include the proposed catastrophic coverage, and Federal annuitants would be charged a Medicare supplemental premium for duplicative coverage, in addition to the premium they pay for FEHB coverage. Also, because the Medicare program is the primary payer of any medical bills with the FEHB plan paying only any remaining costs according to its policy limits, the Medicare-eligible FEHB annuitant is subsidizing or "overpaying" the cost of the FEHB plan, since he pays that same premium as everyone else in that plan even though Medicare is paying a significant proportion of his medical costs. Thus, under the proposed Medicare catastrophic coverage, Medicare-eligible FEHB annuitants would pay a disproportionate share of the cost of a FEHB plan for benefits that would duplicate Medicare's expanded benefits.

II. BACKGROUND INFORMATION ON THE MEDICARE PROGRAM AND PROPOSED CATASTROPHIC COVERAGE CHANGES

A. The Medicare Program

Medicare is a two-part nationwide health insurance program for 30 million aged and 3 million disabled individuals. Part A of Medicare (the Hospital Insurance program) provides protection against hospital and related institutional costs; individuals reaching age 65 are automatically entitled to Part A benefits if they have worked the required number of quarter-years during which the Medicare payroll tax was deducted from their pay. No premium is charged for Part A coverage. Part B of Medicare (the Supplementary Medical Insurance program) covers physicians' services and other health services such as outpatient hospital services, physical therapy, and diagnostic and x-ray services; almost all persons age 65 and older and all persons covered by Part A of Medicare may voluntarily enroll in Part B, for which they pay a monthly premium ($17.90 per month in 1987).

If a retired Medicare beneficiary is also covered by another insurance plan (e.g., an individually-purchased policy which supplements Medicare's coverage, generally known as a medigap policy, or a plan provided by a former employer, such as under the Federal Employees Health Benefits program), Medicare is the primary payer of any medical bill the beneficiary incurs. This means that the medical bill is first paid by Medicare according to Medicare's

coverage and reimbursement rules, and any unpaid portion of the bill is then paid by the other plan according to its coverage and reimbursement rules.

B. Proposed Medicare Catastrophic Coverage Legislation

The 100th Congress is currently considering two bills that would expand current Medicare coverage and provide additional benefits, including a catastrophic limit on beneficiary out-of-pocket costs. These bills are H.R. 2470, which passed the House on July 22, 1987, and S. 1127, which was reported by the Senate Committee on Finance on July 27, 1987. Both bills finance the expanded Medicare coverage in two ways: an increase in the Part B premium and a new income-related supplemental premium that would be collected through the Federal income tax system.

These two bills would apply and calculate the supplemental premium differently. H.R. 2470 requires that all individuals who are eligible for Medicare Part A and who have adjusted gross incomes above a certain amount would pay the supplemental premium. The supplemental premium is determined under H.R. 2470 according to the beneficiary's adjusted gross income. In 1988, if the beneficiary's adjusted gross income is $6,000 or less, no premium would be required. For an adjusted gross income of $6,001 but not over $6,143, the beneficiary would be required to pay an annual supplemental premium of $10. The supplemental premium increases by $10 for every $143 increase in adjusted gross income; the maximum supplemental premium charged in 1988 (for those with adjusted gross incomes over $14,166) would be $580. (See appendix 1 for a table showing the 1988 proposed Medicare catastrophic supplemental premium amounts in H.R. 2470). In future years, the premium amounts would be updated by a Medicare inflation factor, and the adjusted gross income amounts would be

adjusted by the cost-of-living adjustment applicable that year to the income tax brackets.

S. 1127 requires that beneficiaries enrolled in Part B pay the supplemental premium. Since Part B is voluntary, beneficiaries could drop their Part B coverage to avoid paying the supplemental premium; however, they would then not be eligible for the catastrophic coverage changes that S. 1127 makes to both Part A and Part B of Medicare. The supplemental premium is determined under S. 1127 according to the Federal income tax liability (taxes owed) of the Medicare beneficiary. In 1988, for those with a tax liability of at least $150, the supplemental premium would be $12.24 per year for each $150 in tax liability; the maximum supplemental premium in 1988 would be $800, which would be reached when a beneficiary's tax liability exceeded $9,750. The monthly supplemental premium rate would be updated in future years according to the percentage change from the previous year in the cost of the catastrophic benefits.

III. EFFECT OF CATASTROPHIC LEGISLATION ON FEDERAL ANNUITANTS: DIFFERENCES IN SUPPLEMENTAL PREMIUM DEPENDING ON TAX TREATMENT OF RETIREMENT INCOME

A. Background Information on Taxation of Various Types of Pension Income

The amount of supplemental premium a Medicare beneficiary would pay will vary under H.R. 2470 and S. 1127 depending on the tax rules applicable in calculating adjusted gross income and tax liability, respectively. These rules treat different types of income differently. For a retiree with pension income, the tax treatment varies depending on the type of pension, as described below.

1. Federal Annuities

The Civil Service Retirement System (CSRS), the largest Federal pension plan and the only major Federal pension plan that does not include social security coverage, requires "after tax" employee contributions toward the plan while the Federal employee is working. In general, under Federal income tax law both prior to and after the Tax Reform Act of 1986 (P.L. 99-514), the pensions of Federal retirees are fully or mostly taxable.

The vast majority of current Federal annuitants retired prior to July 2, 1986, the effective date for the change in the tax treatment of contributory pension plans mandated by the Tax Reform Act of 1986. Under old tax law,

retirees were not required to pay taxes on the already-taxed portion of their pension until their accumulated monthly pension amounts equaled the previously taxed contributions they had paid into the retirement system while working. The law restricted this "recovery" period during which the pension was not taxed to the first 3 years after retirement. Since most current Federal retirees have already recovered their previously-taxed contributions, they must now pay taxes on all of their pension income.

For Federal workers whose annuity starting date is after July 1, 1986, new tax rules mandated by the Tax Reform Act of 1986 apply. For these Federal retirees, most of the pension is taxed except for a small portion that represents a pro rata return of the worker's previously-taxed contributions. The employee-contributed share of a retiree's monthly pension payment is calculated by dividing the employee's pension contributions by the product of the monthly pension times a life expectancy factor; this results in a percentage called the "exclusion percentage." The exclusion percentage is multiplied by the monthly pension to determine the dollar amount of the retiree's monthly pension that is a return of his or her already-taxed contributions; this monthly dollar amount is not taxed. Once the full amount of the previously-taxed contributions is recouped through the untaxed portion of the annuity payments, the monthly annuity is fully taxable. In general, for these Federal CSRS retirees, on average approximately 90 percent of their pension is taxable, and approximately 10 percent (calculated using the exclusion percentage) is untaxed. The average annual CSRS pension in 1986 was $13,566.

Federal employees hired after December 31, 1983, and others who elect to participate, are covered under the new Federal Employees Retirement System (FERS), which has three components. The major component of FERS is social

security benefits, which are generally not taxed (see the social security description below). The "basic benefit" component of FERS is taxed similar to the CSRS pension for Federal workers retiring after July 1, 1986. Income from the "thrift plan" component is fully taxable. Currently, only a small number of Federal retirees receive benefits under FERS.

The Federal Employees' Retirement System Act of 1986 (P.L. 99-335) allows retiring Federal employees to elect to withdraw, in one lump-sum, their contributions into the retirement system in exchange for a reduced annuity. Most of this lump-sum withdrawal is taxable if received on or after July 2, 1986.

2. Social Security Benefits

Benefits received under the social security system are generally tax-exempt, unless the recipient's adjusted gross income (excluding the yearly social security benefit), plus otherwise tax-exempt interest income, combined with 50 percent of the yearly social security benefit exceeds the following thresholds: $25,000 for individuals, $32,000 for married couples filing joint returns, and zero for married persons filing separate returns. If these thresholds are exceeded, the amount of the yearly social security benefit included in taxable income will be the lesser of (1) one-half of the social security benefit, or (2) one-half of the excess of the following computation over the threshold: the individual's adjusted gross income (excluding the yearly social security benefit), plus otherwise tax-exempt interest income, plus 50 percent of the social security benefit.

Approximately 12 percent of social security recipients are taxed on their social security benefits. The average social security benefit amount for a retired worker in 1987 is $5,890.

3. Private Employer Pensions

Pensions provided by private employers generally do not require employees to contribute. Pensions from such noncontributory plans are subject to taxation when the retiree starts receiving the pension benefit. In those limited cases where "after-tax" employee contributions are made, the taxable portion of the pension benefit is determined using the "exclusion percentage" described above.

4. State and Local Government Pensions

Although there is great variety, most State and local pension plans require employees to make "after-tax" contributions to help finance pension benefits. Therefore, the pensions for these employees are generally taxed except for the employee contribution amount determined by applying the "exclusion percentage" described above. In addition, most State pension plans include social security coverage, whose benefits are generally tax-exempt according to the rules described above.

B. Discussion of the Effect of Medicare Catastrophic Legislation on Federal Annuitants Compared to Retirees With Social Security Benefits

Since the proposed supplemental premium for Medicare catastrophic coverage is based on income as treated by the income tax rules (adjusted gross income in H.R. 2470 and tax liability in S. 1127), the differences in the method of

taxation of various retirement income will result in different supplemental premium amounts depending on the retiree's income source. Most pension income is taxable and, for the most part, social security benefits are not. Thus, a Medicare beneficiary whose income is derived primarily from taxable pensions, such as a Federal annuitant, would pay a higher supplemental premium than one whose income is derived from social security benefits. The larger taxable income amount is partially offset for low income retirees who are eligible for the tax credit for the elderly or permanently and totally disabled. This tax credit is more favorable to retirees without social security, since social security benefits reduce the amount of the tax credit. To the extent that this tax credit reduces tax liability, it would reduce the supplemental premium as calculated under S. 1127.

We have developed several hypothetical examples to illustrate the supplemental premiums for Federal annuitants and for private retirees at various annual income levels. The assumptions that have been used in developing these examples are described on the first page of appendix 2. Our examples use a range of income levels including $6,000 (the average social security benefit in 1987); $14,000 (the average Federal pension amount in 1986); $20,000; $30,000; and $50,000. It should be noted that for various income levels between or above the amounts used in our examples, the supplemental premiums will vary accordingly. The table that follows summarizes the Medicare catastrophic supplemental premium amounts calculated in the examples in appendix 2.

TABLE 1. 1988 Proposed Medicare Catastrophic Supplemental Premiums Based on Hypothetical Income Examples

H.R. 2470

Annual income	Supplemental premium for Federal annuitant	Supplemental premium for private retiree
$6,000 a/	0	0
$14,000 b/	$470.00	$70.00
$20,000 c/	$580.00	$420.00
$30,000 d/	$580.00	$580.00
$50,000 e/	$580.00	$580.00

S. 1127

Annual income	Supplemental premium for Federal annuitant	Supplemental premium for private retiree
$6,000 a/	0	0
$14,000 b/	$ 48.96 f/	$ 12.24
$20,000 c/	$146.88	$ 73.44
$30,000 d/	$293.76	$183.60
$50,000 e/	$697.68	$709.92

a/ For the private retiree, assumes income of $6,000 in social security benefits.

b/ For the private retiree, assumes income of $7,000 in social security benefits and $7,000 in taxable pension income.

c/ For the private retiree, assumes income of $8,000 in social security benefits and $12,000 in taxable pension income.

d/ For the private retiree, assumes income of $9,000 in social security benefits and $21,000 in taxable pension income.

e/ For the private retiree, assumes income of $9,000 in social security benefits and $41,000 in taxable pension income.

f/ If the tax credit for the elderly or the permanently and totally disabled is not taken, the supplemental premium would be $73.44.

As shown in the above table and provided in detail in appendix 2, example 1, under H.R. 2470 and S. 1127 neither a Federal annuitant whose only income is derived from a $6,000 Federal annuity nor a private retiree with income derived solely from $6,000 in social security benefits would be required to pay a supplemental premium in 1988.

The other pension income levels used in our examples would each result in a supplemental premium for both the Federal annuitant and for the private retiree with social security benefits. At the $14,000, $20,000, and $30,000 income levels, the supplemental premium for the Federal annuitant would be equal to or larger than the premium for the private retiree with social security benefits. The reason for the higher premium amount for the Federal annuitant is that the Federal pension is taxed to a greater extent (in our examples we assumed that 90 percent was taxed) than social security benefits. Since the supplemental premiums are based on income (adjusted gross income in H.R. 2470 and tax liability in S. 1127), the higher the income, the higher the supplemental premium.

At the $14,000 income level, under H.R. 2470 the Federal annuitant in our example would pay an annual supplemental premium that would be almost seven times greater than the supplemental premium for the private retiree. Under S. 1127, the Federal annuitant's supplemental premium would be four times greater than the private retiree's; if the Federal annuitant did not take the tax credit for the elderly or the permanently and totally disabled, his or her supplemental premium would be six times greater than that of the private retiree. (See appendix 2, example 2.)

At the $20,000 income level, our example results in a supplemental premium under H.R. 2470 that would be almost one and a half times greater for the Federal annuitant than for the private retiree; under S. 1127, the Federal

annuitant's premium would be two times greater than the premium for the private retiree. (See appendix 2, example 3.)

At the $30,000 income level, under H.R. 2470 the Federal annuitant and the private retiree in our example would pay the same maximum supplemental premium amount; under S. 1127, the Federal annuitant's premium would be more than one and a half times greater than that of the private retiree. (See appendix 2, example 4.)

At the $50,000 income level, under H.R. 2470 the Federal annuitant and the private retiree would pay the same maximum supplemental premium amount. Under S. 1127, the Federal annuitant would pay a premium that is almost 2 percent lower than the private retiree's premium. This is because at this higher income level, half (or $4,500) of the private retiree's $9,000 social security benefit is taxed, resulting in an adjusted gross income amount ($45,500) that is larger than the adjusted gross income of the Federal annuitant ($45,000). (See appendix 2, example 5.)

IV. EFFECT OF CATASTROPHIC LEGISLATION ON FEDERAL ANNUITANTS: DUPLICATION OF FEDERAL HEALTH BENEFITS COVERAGE AND MEDICARE BENEFITS

A. Background Information on the Federal Employees Health Benefits Program and Coordination with Medicare

Federal annuitants who meet eligibility requirements may elect to purchase a health benefits plan from the Federal Employees Health Benefits (FEHB) program. The numerous plans from which to choose and their premium rates are the same for Federal annuitants as they are for Federal employees. Although the plans offer a variety of different benefits, all provide some amount of coverage for hospital and physicians' services, and all provide full payment of covered medical expenses once a catastrophic limit on enrollee out-of-pocket expenses has been met. All FEHB plans offer self-only and family coverage, and many plans offer high and low options, the low option providing fewer benefits with greater enrollee cost-sharing amounts than the high option. No plans offer a Medicare supplemental policy (i.e., a plan that only supplements Medicare's benefits, sometimes known as a medigap policy); however, the plans waive their coinsurance and deductible amounts for Medicare beneficiaries. Premiums for the FEHB plans are shared by the Federal Government and the enrollee, with the Federal Government paying approximately 60 percent of the premium.

According to a survey conducted by the General Accounting Office (GAO), approximately 53 percent of Federal annuitants and survivors age 65 and older (543,000 individuals) were covered by both the FEHB program and Medicare Part A as of December 1981. In testimony before the Senate Governmental Affairs Committee on September 23, 1987, a representative of the Office of Personnel Management (OPM) stated that the number of annuitants covered by both programs is approximately 760,000. OPM has begun an effort to secure more accurate data by matching their annuity records with Medicare beneficiary files.

The benefits available under the various FEHB plans frequently duplicate or are more generous than the benefits available under the current Medicare program, particularly the benefits for catastrophic coverage and inpatient hospital services. Since Medicare is the primary payer of a medical bill when a Federal annuitant has both Medicare and a FEHB plan, the FEHB plan pays (according to its coverage and reimbursement rules) only the remaining portion of the bill, generally waiving any deductible or coinsurance amounts for the Medicare beneficiary. In this manner, often 100 percent of the medical bill for a Federal annuitant with both coverages is reimbursed.

Many Federal annuitants with FEHB coverage who wish to continue their FEHB coverage after becoming eligible for Medicare frequently enroll in a low option FEHB plan, thus reducing the extent of duplication of the Medicare and the FEHB plan benefits and paying a lower FEHB premium than they would under a high option plan. (An exception might be a Federal annuitant eligible for both FEHB and Medicare who purchases family coverage under a FEHB plan in order to provide insurance for a spouse under age 65 and not yet eligible for Medicare coverage, if the annuitant wants more extensive coverage for the spouse than that provided by low option.)

However, even the low option FEHB plans duplicate Medicare's coverage to some degree. Because Medicare is primary payer, Federal annuitants with Medicare generally have low claims costs under the FEHB plan. However, such annuitants pay the same premium as the other enrollees (e.g., employees or Federal annuitants without Medicare) in that FEHB plan. This means that the FEHB annuitant with Medicare coverage (and the Federal Government which pays its 60 percent premium share) is subsidizing a portion of a FEHB plan's costs for all who purchase that plan because that annuitant is overpaying for the benefits he or she actually receives from that FEHB plan.

The issue of better coordination between the FEHB program and Medicare has been raised several times in the past. The Social Security Amendments of 1972 (P.L. 92-603) provided in section 1862(c) of the Social Security Act that beginning January 1, 1975, Medicare would not pay for services also covered under a FEHB plan unless the FEHB program were modified to make available to Medicare-eligible FEHB enrollees one or more health benefits plans which supplemented Medicare. The deadline was extended until January 1, 1976, by P.L. 93-480. After considering proposals from the Administration and from GAO for coordination of the two programs, Congress included in P.L. 94-182 a repeal of section 1862(c), indicating in a Finance Committee report (Senate Report No. 94-549) that:

> The substantial costs of these proposals need to be weighed against the increased benefit protection or improved equity they would provide for people covered under both FEHB and medicare. . . . Although it can be argued that more generous provisions than now exist for coordination of FEHB and medicare are merited, the committee is not convinced that equity requires the Government to substantially increase its expenditures under the two programs in an effort to accomplish this. . . . Some offsetting of the benefits of one program against the other, such as now exists, seems justified in view of the major contributions the Government makes toward the financing of both programs.

One issue discussed in the early 1970's FEHB/Medicare coordination debate is that the subsidy that Medicare-eligible Federal annuitants provide to a FEHB plan would no longer exist if such annuitants were offered the opportunity to leave the pool of all enrollees covered by the plan to purchase a Medicare supplemental policy option. Depending on the number of such annuitants in that plan, the loss of this subsidy could result in increased premium costs to all enrollees who remain in the pool (including employees and Federal annuitants not eligible for Medicare).

Subsequent examination of coordination between Medicare and FEHB occurred during consideration of the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) when a proposal was made, but not adopted, to make Medicare a secondary payer to the FEHB program. In 1982, a study of the FEHB program by William M. Mercer, Incorporated, commissioned by the House Committee on Post Office and Civil Service, recommended that health benefits for annuitants under FEHB should be separate from those for active employees. Suggested in their report (Review of the Federal Employees Health Benefits Program, July 1982) were a number of changes affecting Medicare-eligible annuitants, including a proposal that "the form of coordination of Medicare be changed from the current double-coverage provision to a Medicare integration provision." Several bills introduced in the 98th Congress included provisions for Medicare supplemental policies under the FEHB program (S. 1685, Durenberger; S. 2027, Stevens); hearings were held, but neither bill was enacted.

B. Discussion of the Effect of Medicare Catastrophic Legislation on Federal Annuitants Eligible for FEHB and Medicare

If Medicare benefits are expanded by the enactment of either Medicare catastrophic coverage bill, greater duplication of the benefits provided by

Medicare and the FEHB plans than now exists would occur. The subsidy that Medicare-eligible Federal annuitants currently provide to FEHB plans by paying a FEHB premium for benefits actually paid for by Medicare would also be even greater because Medicare as primary payer would pay an even greater amount of the medical bills of those annuitants under its expanded coverage. In addition, the premiums that such annuitants would pay for FEHB plan coverage would yield them even fewer benefits than would be provided to other FEHB plan enrollees for the same premium.

In addition to the issue of duplication of benefits and overpayment of the FEHB premium, if Medicare were expanded to include the catastrophic coverage provisions, the Medicare-eligible Federal annuitant would be required to pay a new Medicare supplemental premium for catastrophic coverage that he or she might not need because of the relatively generous benefits available under the FEHB plans.

Another issue is that if Medicare-eligible Federal annuitants were required to pay a new Medicare supplemental premium for coverage they are currently already receiving from Medicare and their FEHB plans, their payments would, in effect, substitute for the FEHB premium payment, approximately 60 percent of which is subsidized by the Federal Government. This represents, in effect, a loss of a Federal benefit to which the annuitant is entitled under the FEHB program.

If the Medicare catastrophic coverage provisions were enacted, annuitants eligible for both Medicare and FEHB coverage would have two options if they could not afford or did not wish to pay premiums for duplicative coverage. Similar to the option available to individual purchasers of private medigap policies, they could drop their FEHB plan coverage. However, annuitants might be reluctant to do so because (1) the FEHB program offers a yearly choice of

plans that have relatively generous coverage; (2) historically the FEHB program has been comparatively stable, unlike the Medicare program which faces yearly scrutiny during the budget reconciliation process; (3) the FEHB program provides that annuitants who cancel their enrollment in the FEHB program cannot reenroll, preventing the annuitant from rejoining the FEHB program if in the future he perceives that Medicare's benefits are less favorable or its premiums are too expensive; (4) the annuitant receives a FEHB premium subsidy of approximately 60 percent from the Federal Government; and (5) the annuitant may wish to remain in the FEHB program to cover a spouse who is not yet age 65 and thus not eligible for Medicare and may have no other source of health insurance coverage.

Under S. 1127, another option for a Federal annuitant eligible for both programs would be to cancel enrollment in Part B of Medicare. The annuitant would then not be eligible for any of the Part A or Part B catastrophic coverage changes included in the bill (only current Part A benefits would remain) and would not be required to pay the supplemental premium or the Part B premium, including any Part B increases necessary to fund the catastrophic coverage. Since Medicare-eligible Federal annuitants subsidize the cost of the FEHB program, reducing their Medicare coverage would result in increased costs to the FEHB program. Cancelling Medicare coverage is not an option for a beneficiary under H.R. 2470, where payment of the supplemental premium is required of individuals entitled to Medicare Part A, which is not voluntary.

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APPENDIX 1. 1988 PROPOSED MEDICARE CATASTROPHIC SUPPLEMENTAL PREMIUM AMOUNTS PROVIDED IN H.R. 2470

"If the adjusted gross income for the taxable year is: Over:	But not over:	The annual premium for the taxable year is:
$ 0	$ 6,000	$ 0
6,000	6,143	10
6,143	6,287	20
6,287	6,430	30
6,430	6,573	40
6,573	6,716	50
6,716	6,860	60
6,860	7,003	70
7,003	7,146	80
7,146	7,289	90
7,289	7,433	100
7,433	7,576	110
7,576	7,719	120
7,719	7,862	130
7,862	8,006	140
8,006	8,149	150
8,149	8,292	160
8,292	8,436	170
8,436	8,579	180
8,579	8,722	190
8,722	8,865	200
8,865	9,009	210
9,009	9,152	220
9,152	9,295	230
9,295	9,438	240
9,438	9,582	250
9,582	9,725	260
9,725	9,868	270
9,868	10,011	280
10,011	10,155	290
10,155	10,298	300
10,298	10,441	310
10,441	10,585	320
10,585	10,728	330
10,728	10,871	340
10,871	11,014	350
11,014	11,158	360
11,158	11,301	370
11,301	11,444	380
11,444	11,587	390
11,587	11,731	400
11,731	11,874	410
11,874	12,017	420
12,017	12,160	430
12,160	12,304	440
12,304	12,447	450
12,447	12,590	460
12,590	12,734	470
12,734	12,877	480
12,877	13,020	490
13,020	13,163	500
13,163	13,307	510
13,307	13,450	520
13,450	13,593	530
13,593	13,736	540
13,736	13,880	550
13,880	14,023	560
14,023	14,166	570
14,166		580.

APPENDIX 2. THEORETICAL EXAMPLES OF PROPOSED MEDICARE CATASTROPHIC SUPPLEMENTAL PREMIUMS USING DIFFERENT PENSION INCOME ASSUMPTIONS

The assumptions used in calculating the examples that follow include:

--Our hypothetical retirees are single, with no survivor benefits, in 1988.

--The retirees do not itemize deductions when filing income taxes; they take the standard deduction ($3,000), the extra standard deduction for the aged ($750), and a personal exemption ($1,950).

--The retirees take the tax credit for the elderly or the permanently and totally disabled, which is calculated as follows: $5000 minus nontaxable social security benefits minus 1/2 (adjusted gross income-$7,500) times 15 percent.

--We applied an estimated average 10 percent exclusion percentage to the Federal annuitant's pension income in each example to determine the amount that is not subject to taxation for annuitants who retire after July 1, 1986; however, the actual percentage varies depending on the amount of employee contributions, the annual pension, and life expectancy at age of retirement.

--The private retiree's income is assumed to include a certain amount of social security benefits, to which an amount of taxable pension income is added so that the total equals the Federal pension amount. The hypothetical amounts of social security benefits at the various pension income levels used in our examples are as follows: at $6,000 in income, all is assumed to be social security benefits; at $14,000 in income, $7,000 is social security benefits; at $20,000 in income, $8,000 is social security benefits; at $30,000 and $50,000 in income, $9,000 is social security benefits.

--The amount of taxable social security benefits was determined in our examples according to the following standard formula. If the private retiree's adjusted gross income (excluding the yearly social security benefit), plus otherwise tax-exempt interest income, combined with 50 percent of the yearly social security benefit exceeded the $25,000 threshold for individuals, the amount of the social security benefit included in taxable adjusted gross income would be the lesser of (1) one-half of the social security benefit, or (2) one-half of the excess of the following computation over the threshold: the individual's adjusted gross income (excluding the yearly social security benefit), plus otherwise tax-exempt interest income, plus 50 percent of the social security benefit.

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EXAMPLE 1. 1988 Proposed Medicare Catastrophic Supplemental Premiums Under H.R. 2470 and S. 1127 for Federal Annuitants vs. Private Retirees, $6,000 Annual Income

H.R. 2470

	Federal annuitant	Private retiree
Gross income	$6,000 a/	$6,000 b/
Adjusted gross income (taxable pension amount)	5,400 a/	0 b/
Supplemental premium	0	0

S. 1127

Gross income	$6,000 a/	$6,000 b/
Adjusted gross income (taxable pension amount)	5,400 a/	0 b/
Standard deduction	-3,000	-3,000
Extra standard deduction for the aged	- 750	- 750
Personal exemption	-1,950	-1,950
Taxable income	0	0
Income tax bracket	NA	NA
Tax liability	0	0
Tax credit for the elderly	0	0
Tax liability after tax credit	0	0
Supplemental premium	0	0

a/ Assumes a Federal annuity of $6,000, 90 percent (or $5,400) of which is subject to taxation.

b/ Assumes a private retiree income of $6,000 composed entirely of untaxed social security benefits.

EXAMPLE 2. 1988 Proposed Medicare Catastrophic Supplemental Premiums Under H.R. 2470 and S. 1127 for Federal Annuitants vs. Private Retirees, $14,000 Annual Income

H.R. 2470

	Federal annuitant	Private retiree
Gross income	$14,000 a/	$14,000 b/
Adjusted gross income (taxable pension amount)	12,600 a/	7,000 b/
Supplemental premium	470	70

S. 1127

Gross income	14,000 a/	14,000 b/
Adjusted gross income (taxable pension amount)	12,600 a/	7,000 b/
Standard deduction	-3,000	-3,000
Extra standard deduction for the aged	- 750	- 750
Personal exemption	-1,950	-1,950
Taxable income	6,900	1,300
Income tax bracket	15%	15%
Tax liability	1,035	195
Tax credit for the elderly	- 367 c/	0
Tax liability after tax credit	668 c/	195
Supplemental premium	48.96 c/	12.24

a/ Assumes a Federal annuity of $14,000, 90 percent (or $12,600) of which is subject to taxation.

b/ Assumes a private retiree income of $14,000 composed of $7,000 in untaxed social security benefits and $7,000 in taxable pension income.

c/ If the tax credit for the elderly were not taken, the supplemental premium would be $73.44.

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EXAMPLE 3. 1988 Proposed Medicare Catastrophic Supplemental Premiums Under H.R. 2470 and S. 1127 for Federal Annuitants vs. Private Retirees, $20,000 Annual Income

H.R. 2470

	Federal annuitant	Private retiree
Gross income	$20,000 a/	$20,000 b/
Adjusted gross income (taxable pension amount)	18,000 a/	12,000 b/
Supplemental premium	580	420

S. 1127

Gross income	20,000 a/	20,000 b/
Adjusted gross income (taxable pension amount)	18,000 a/	12,000 b/
Standard deduction	-3,000	-3,000
Extra standard deduction for the aged	- 750	- 750
Personal exemption	-1,950	-1,950
Taxable income	12,300	6,300
Income tax bracket	15%	15%
Tax liability	1,845	945
Tax credit for the elderly	0	0
Tax liability after tax credit	1,845	945
Supplemental premium	146.88	73.44

a/ Assumes a Federal annuity of $20,000, 90 percent (or $18,000) of which is subject to taxation.

b/ Assumes a private retiree income of $20,000 composed of $8,000 in untaxed social security benefits and $12,000 in taxable pension income.

EXAMPLE 4. 1988 Proposed Medicare Catastrophic Supplemental Premiums Under H.R. 2470 and S. 1127 for Federal Annuitants vs. Private Retirees, $30,000 Annual Income

H.R. 2470

	Federal annuitant	Private retiree
Gross income	$30,000 a/	$30,000 b/
Adjusted gross income (taxable pension amount)	27,000 a/	21,250 b/
Supplemental premium	580	580

S. 1127

Gross income	30,000 a/	30,000 b/
Adjusted gross income (taxable pension amount)	27,000 a/	21,250 b/
Standard deduction	-3,000	-3,000
Extra standard deduction for the aged	- 750	- 750
Personal exemption	-1,950	-1,950
Taxable income	21,300	15,550
Income tax bracket	28%	15%
Tax liability	3,644	2,332
Tax credit for the elderly	0	0
Tax liability after tax credit	3,644	2,332
Supplemental premium	293.76	183.60

a/ Assumes a Federal annuity of $30,000, 90 percent (or $27,000) of which is subject to taxation.

b/ Assumes a private retiree income of $30,000 composed of $9,000 in social security benefits ($250 of which is taxable) and $21,000 in taxable pension income.

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EXAMPLE 5. 1988 Proposed Medicare Catastrophic Supplemental Premiums Under H.R. 2470 and S. 1127 for Federal Annuitants vs. Private Retirees, $50,000 Annual Income

H.R. 2470

	Federal annuitant	Private retiree
Gross income	$50,000 a/	$50,000 b/
Adjusted gross income (taxable pension amount)	45,000 a/	45,500 b/
Supplemental premium	580	580

S. 1127

Gross income	50,000 a/	50,000 b/
Adjusted gross income (taxable pension amount)	45,000 a/	45,500 b/
Standard deduction	-3,000	-3,000
Extra standard deduction for the aged	- 750	- 750
Personal exemption	-1,950	-1,950
Taxable income	39,300	39,800
Income tax bracket	28%	28%
Tax liability	8,684	8,824
Tax credit for the elderly	0	0
Tax liability after tax credit	8,684	8,824
Supplemental premium	697.68	709.92

a/ Assumes a Federal annuity of $50,000, 90 percent (or $45,000) of which is subject to taxation.

b/ Assumes a private retiree income of $50,000 composed of $9,000 in social security benefits ($4,500 of which is taxable) and $41,000 in taxable pension income.

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